Audit & Risk Committee

Thu 17 June 2021, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:30
30 min

1. MEMBERS' TRAINING SESSION - THE ANNUAL ACCOUNTS: ROLE & FUNCTION OF THE AUDIT & RISK COMMITTEE

Trish Fraser

Slides circulated separately.

14:30 - 14:31
1 min

2. Apologies for Absence

Martin Black

14:31 - 14:32
1 min

3. Declaration of Members' Interests

Martin Black

14:32 - 14:35
3 min

4. Minutes of the Previous Meeting held on 13 May 2021

Martin Black

Item 4 - A&R Minutes 130521 - unconfirmed.pdf (8 pages)

14:35 - 14:40
5 min

5. Action List / Matters Arising

Martin Black

Item 5 - A&R Action List June.pdf (1 pages)

14:40 - 15:00
20 min

6. GOVERNANCE - GENERAL

6.1. Draft Committee Annual Assurance Statement

Gillian MacIntosh

Item 6.1 - SBAR Draft A&R Annual Assurance Statement.pdf (3 pages)
Item 6.1 - DRAFT A&R Annual Statement of Assurance 202021.pdf (17 pages)

6.2. Draft Governance Statement

Margo Mcgurk

Item 6.2 - SBAR Draft Gov Statement.pdf (3 pages)
Item 6.2 - Appendix 1 - NHS FIFE AA Governance Statement.pdf (9 pages)

6.3. Draft Letter of Significant Issues of Wider Interest

Kevin Booth

- Item 6.3 - SBAR Draft Letter of Significant Issues of Wider Interest.pdf (3 pages)
- Item 6.3 - Appendix 1 - 2020-21 - Significant issues letter.pdf (2 pages)
- Item 6.3 - Appendix 2 - Draft Wider Issues Reponse Letter.pdf (11 pages)

6.4. Whistleblowing Standards Implementation

Linda Douglas

- Item 6.4 - SBAR Whistleblowing Standards Implementation.pdf (4 pages)

15:00 - 15:15
15 min

7. GOVERNANCE - INTERNAL AUDIT

7.1. Internal Audit Progress Report & Summary Report

Barry Hudson

- Item 7.1 - SBAR Internal Audit Progress Report.pdf (3 pages)
- Item 7.1 - Appendix A - Internal Audit Progress Report.pdf (5 pages)

7.2. Internal Audit Follow Up Report

Barry Hudson

- Item 7.2 - SBAR Audit Follow Up Report.pdf (17 pages)

15:15 - 15:35
20 min

8. GOVERNANCE - EXTERNAL AUDIT

8.1. NHS Fife Interim Management Report 2020/21

Trish Fraser

- Item 8.1 - NHS Fife Management Report.pdf (8 pages)

15:35 - 15:49
14 min

9. RISK

9.1. Risk Management Leadership

Margo Mcgurk

- Item 9.1 - SBAR Risk Management Paper.pdf (3 pages)
- Item 9.1 - Appendix 1 - Risk Management Leadership Paper to EDG.pdf (6 pages)

9.2. Board Assurance Framework

Pauline Anne Cumming

- Item 9.2 - SBAR on Board Assurance Framework.pdf (5 pages)
- Item 9.2 - Appendix 1 - NHS Fife BAF Financial Sustainability.pdf (1 pages)
- Item 9.2 - Appendix 2 - NHS Fife BAF Environmental Sustainability.pdf (2 pages)
- Item 9.2 - Appendix 3 - NHS Fife BAF Workforce Sustainability.pdf (2 pages)
- Item 9.2 - Appendix 4 - NHS Fife BAF Quality & Safety.pdf (2 pages)
- Item 9.2 - Appendix 5 - NHS Fife BAF Strategic Planning.pdf (2 pages)
- Item 9.2 - Appendix 6 - NHS Fife BAF Integration Joint Board.pdf (1 pages)
- Item 9.2 - Appendix 7 - NHS Fife BAF Digital and Information.pdf (2 pages)

9.3. Corporate Risk Register Quarterly Report

Pauline Anne Cumming

- Item 9.3 - SBAR Update on Corporate Risk Register arrangements.pdf (2 pages)
- Item 9.3 - Corporate Risk Register.pdf (7 pages)

9.3.1.

9.4. Annual Risk Management Report 2020/21

Pauline Anne Cumming

- Item 9.4 - SBAR Risk Management Annual Report 2020-2021.pdf (2 pages)
- Item 9.4 - Appendix 1 - NHS Fife Risk Management Annual Report 2020-2021.pdf (14 pages)

15:49 - 15:58
9 min

10. OTHER

10.1. Feedback from the Sharing Intelligence for Health & Care Group

Gillian MacIntosh

- Item 10.1 - SBAR SIHCG letter A&R.pdf (4 pages)
- Item 10.1 - SIHCG Feedback Letter NHSFIFE.pdf (4 pages)

10.2. Issues for escalation to NHS Board

Martin Black

15:58 - 16:00
2 min

11. ANY OTHER COMPETENT BUSINESS

16:00 - 16:00
0 min

12. DATE OF NEXT MEETING - Thursday 16 September 2021

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON 13 MAY 2021 AT 2 PM VIA MS TEAMS

Present:

M Black, Non-Executive Member & Chair
S Braiden, Non-Executive Member
Cllr D Graham, Non- Executive Member (part)
A Lawrie, Non-Executive Member
K Macdonald, Non-Executive Member

In Attendance:

C Potter, Chief Executive
K Booth, Head of Financial Services & Procurement
A Clyne, Audit Scotland
P Cumming, Risk Manager
P Fraser, Audit Scotland
P King, minutes
T Gaskin, Chief Internal Auditor
B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
H Thomson, Observer

1. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting, in particular Kirstie Macdonald, the new Non-Executive Whistleblowing Champion, as a new member of the Committee, Pauline Cumming as a regular attendee at the Committee going forward, and Hazel Thomson who will provide the secretariat to the Committee from June 2021, after she joins NHS Fife as the new Board Committee Support Officer.

The notes are being recorded with the Echo Pen to aid production of the minutes. These recordings are also kept on file for any possible future reference.

There were no apologies for absence.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 18 March 2021

The minute of the last meeting was **agreed** as an accurate record.

4. Action List / Matters Arising

The Committee **noted** the outstanding action, which would remain a standing item until it had been resolved at year end.

5. GOVERNANCE - GENERAL

5.1. Committee Assurance Principles

Mr Gaskin introduced the paper, which outlined the development of a consistent and coherent approach to the provision of assurance in line with the governance mapping principles recommended for adoption by all NHS Scotland Health Boards, under the Scottish Public Finance Manual. The main purpose of the paper was to inform the Board and Committees' approach to considering ways in which to focus attention on key areas and giving clear guidance on how to support delivering strong assurance and due prominence to risk awareness and risk management. The Committee Assurance principles were attached as Appendix 1 of the paper.

It was noted that the paper had previously been considered by the Executive Directors' Group and had received full support. Initial discussion had also taken place with the Board Chair and Vice Chair about how to introduce it wider across committees. It was proposed to discuss with individual Committee Chairs in the first instance, as a means to aiding the agenda planning process with Executive Leads, and then with a view to bringing to the Board as part of the work being undertaken in the Autumn around active governance, which will cover how the Board should continue to best seek assurance and undertake scrutiny.

The Committee **considered** the principles and **endorsed** them for use by committees in the manner described in the paper, following further discussion with Committee Chairs.

Cllr Graham joined the meeting.

5.2. Committee Annual Workplan 2021/22

The Annual Workplan 2021/22 was presented to the Committee. It was noted that the workplan for the year reflected the September 2021 date for consideration of this year's annual accounts and a timetable had been agreed with Audit Scotland. Work was progressing and draft accounts were due to be passed to Audit Scotland by 31 May 2021.

Ms Fraser asked that the workplan be updated under the Annual Accounts section to include the ISA260 report to those charged with governance, and this was agreed.

Action: G MacIntosh

The Committee **approved** the Annual Workplan 2021/22, with the addition of the ISA260 report noted above and subject to any necessary changes being made to reflect potential scheduling alterations due to the current Coronavirus pandemic.

5.3. Audit & Risk Committee Self-Assessment Report

Dr MacIntosh introduced the self-explanatory report, which is undertaken across all committees each spring. It was noted that the response rate across committees as a whole was not as good as previous years, as a result of operational pressures on staff

due to Covid-19 at the time responses were being sought. Full details on the outcome of the self-assessment exercise were listed in the Appendix to the paper.

The areas for improvement were highlighted, namely membership vacancies (which had largely since been addressed, though noting that the current recruitment round for a new Non Executive Board Member is expected to include a specific request for financial skills as part of that recruitment campaign). There was an appetite for further training opportunities and a session had been agreed with the External Auditors for June 2021. Members were asked to send on any potential topics for future sessions to either the Chair or Board Secretary. Members were also encouraged to complete various audit & risk associated modules on the e-learning platform Turas, links to which had been previously circulated to members.

The Committee **noted** the outcome of the Committee's recent self-assessment exercise and **agreed** the actions to be implemented.

5.4. Draft Audit & Risk Committee Annual Statement of Assurance 2020/21

Dr MacIntosh advised that this was a draft version of the Audit & Risk Committee Annual Statement of Assurance and this was presented for Members' comments, before coming back to the Committee in final form at the September meeting, once final statements of assurance had been received from the other Board committees and the Integration Joint Board. The difference in the timing for the annual accounts process of the Integration Joint Board was commented upon, but it was noted this was due to Councils having a later timeframe for annual accounts than NHS Boards. Margo McGurk confirmed that work continued to integrate and co-ordinate with the Integration Joint Board as much as possible, though the disconnect on timing was unlikely to be resolved.

Noting the content, the Audit & Risk Committee **approved** the content of the draft Audit & Risk Committee Annual Statement of Assurance as it currently stands and asked that any comments, amendments or additions be forwarded to the Board Secretary.

5.5. Payments to Primary Care Practitioners

Mrs McGurk presented the annual report for assurance to the Committee around the accuracy and validity of all payments made to Primary Care Practitioners, which is a key element of the financial control arrangements across that aspect of our resources.

As a consequence of Covid-19, it was noted that NHS Fife had not met routinely with representatives from Practitioner Services Division (PSD) to monitor the payment verification work undertaken by PSD on behalf of the Health Board for Medical, Dental or Ophthalmic services. The majority of visits had been suspended nationally during lockdown, with staff redirected to essential work related to the pandemic, in particular Test and Protect. A number of local review activities did continue and where there were issues there was nothing of significance to report. Section 2.3 of the report detailed the range of updates received throughout the year. Of particular note, the Primary Medical Services (Directed Enhanced Services) Directions 2018 had been amended to include the Covid-19 vaccination programme, which can be aligned with

the level of reporting and scrutiny to the committees of the Board and the Board itself as a key area of focus.

In summary, the report provided an update on the process for payments to Practitioner Services, with an assurance that whilst the payment verification element was suspended, local controls were maintained and close attention paid to any process changes in year.

A few drafting comments had been left on the report and the report would be amended to ensure these were removed prior to the papers being published.

Action: M McGurk

The Committee **noted** the findings of the report.

5.6. Annual Review of Code of Corporate Governance

Dr MacIntosh presented the updated Code of Corporate Governance, which incorporated recent reviews by each Board committee of their individual Terms of Reference and ensured the current text reflected present structures, terminology and job titles. It also proposed clarifying changes to the Standing Financial Instructions, recommended by the Director of Finance and Head of Financial Services & Procurement, bringing the Code up-to-date and reflective of current practice.

Mr Booth stated that a review of the underlying Financial Operating Procedures would be undertaken in late summer/early autumn, which might prompt further review of the Standing Financial Instructions thereafter.

The Committee **recommended approval** of the updated Code to the NHS Fife Board.

5.7. NHS Fife Strategy Development

It was noted that this work is in the early stages of development and an update will be provided to the next meeting of the Committee. Any reflections or comments since the presentation to the Board Development Session held in April could be forwarded to the Chief Executive or Director of Finance & Strategy.

The Committee **noted** that an update would be provided to the next meeting of the Committee.

6. GOVERNANCE – INTERNAL AUDIT

6.1. Internal Audit Progress Report and Summary Report

Mr Hudson spoke to the paper, which provided comprehensive assurance to the Committee on the progress of the 2020/21 Internal Audit Plan. Internal Audit had experienced some delays in progressing audits but Members were assured that all work will be completed to allow consideration as part of the Annual Report for 2020/21. Section 2.3 of the SBAR provided details of further advice/input provided to NHS Fife, together with ongoing improvement activities undertaken since the last meeting of the Committee in March 2021. These were highlighted to the Committee.

Appendix A provided detail around the internal audit progress and showed those reports which are at the stages of finalised draft and work in progress.

Mrs McGurk took the opportunity to thank both Mr Gaskin and Mr Hudson for the positive engagement in terms of the categorisation of findings and for including the additional category of Moderate. She also thanked them for the advice, guidance and support received over the past few months and in particular for securing solid improvements in the area of information governance and security.

The Committee **noted** the ongoing progress on the delivery of the Internal Audit Plan and **approved** the revised recommendation priorities and assurance definitions for use in all future audit reports as set out in Appendix B.

6.2. Draft Internal Audit Plan 2021/22

Mr Gaskin reported that Internal Audit had produced a draft operational plan for 2021/22, which has been mapped to the extant Board Assurance Framework and the highest risks from the risk register and Covid-19 risk register. The Plan is different in style from previous years, reflecting the impact of Covid on business-as-usual activities, and that areas for review have been based on discussions with the Director of Finance & Strategy with input from the wider Executive Directors' Group. Given that NHS Fife is in the process of revisiting the risk profile and reassessing the Corporate Risk Register, the plan focuses on short-term needs and known strategic objectives for the year. It was highlighted that this is an interim plan, which will require to be reviewed later in the year based on the updated risk register. Members were asked to feedback any comments/observations to Mr Gaskin.

The Audit & Risk Committee **discussed** and **approved** the current iteration of the draft Internal Audit Plan 2021/22.

6.3. Internal Audit – Follow Up Report

Mr Hudson spoke to the standard follow-up report provided by Internal Audit showing the status of all remaining internal audit recommendations as at 28 April 2021. He advised that work continued to evolve and enhance the audit report, taking on board feedback received, noting in particular the outcome of the review of historic recommendations and an enhancement to Appendix C whereby audit has assessed progress made in relation to recommendations with extended target dates and the inclusion of 'Red / Amber / Green' (RAG) status in Appendix F. The Audit Follow-Up Protocol had also been amended to reflect a change in focus to address outstanding recommendations and improve response times. Feedback on the report style was welcomed from Members of the Committee.

In response to a query, Mrs McGurk directed Members to Appendix C and the column entitled 'original and extended due dates' as the area of particular interest in terms of Audit & Risk scrutiny on progress. Mr Gaskin suggested that once the current outstanding actions had been completed, a colour coding system could be used to highlight the recommendations that had been extended for some time and this was agreed.

The Committee **considered** the current status of recommendations detailed in the report; **noted** the exercise undertaken to rationalise recommendations; and **approved** the revised internal audit follow-up protocol.

7. GOVERNANCE - EXTERNAL AUDIT

7.1. Audit Planning Memorandum – Patients' Private Funds

Mr Booth explained that the report set out the timeframe and proposed approach for the external audit of Patients' Private Funds Abstract of Receipts and Payments for 2020/21, carried out by Thomson Cooper Accountants. Attention was drawn to section 2.3 of the covering SBAR, which referred to the term "limitation of scope". This meant that the auditors may be unable to do the level of testing that they would normally do to validate the financial position of the Patients' Private Funds, as there are potential restrictions around access to wards due to Covid-19, although the auditors were planning to visit Queen Margaret and Lynebank Hospitals. This is a national issue and there will be a national co-ordination of how this is reflected in the annual accounts.

The Committee **noted** the Audit Planning Memorandum for the Patients' Private Funds.

7.2. Audit Planning Memorandum – Fife Health Charity

Mr Booth noted that this report was similar in content to the previous paper and advised that the audit will be carried out by Thomas Cooper Accountants. Attention was once again drawn to section 2.3 in the cover paper related to the potential "limitation of scope".

The Committee **noted** the external Audit Planning Memorandum for Fife Health Charity.

8. RISK

Mrs McGurk introduced the suite of papers related to risk, noting this was an important are of focus and consideration by the Committee. She commented that the sequencing of the Board Assurance Framework (BAF) and supporting documentation was largely out-of-date, as the versions provided referenced the position at the end of January (as the BAF was not considered at the March Committee meetings due to the reprioritisation of agendas in the light of Covid-19). As part of the broader work on risk management, the sequencing and timing of submitting the BAF to this Committee will be reviewed to bring in line with reporting to other Board committees, thus ensuring Audit & Risk had the most recent iterations.

Ensuring NHS Fife's commitment as an organisation to embed an effective risk culture, a detailed review of the current arrangements supporting the co-ordination of risk management across the organisation was undertaken. The Executive Directors' Group approved a recent proposal to elevate the profile of risk management and fully integrate with the strategic planning process and a paper would be submitted to the next meeting of the Committee detailing this.

8.1. Board Assurance Framework

Mrs McGurk introduced this report.

There were two proposed changes related to the Financial Sustainability BAF, where the risk score was lowered from high to moderate on the basis that NHS Fife had confirmed a small underspend position in 2020/21. A more strategic term risk for financial sustainability was being considered and would be reported to the next meeting. A change was also being proposed to the Strategic Planning BAF to reflect work on the development of a new Health and Wellbeing Strategy.

Questions were asked in relation to the number of high risks that had been at that level for over one year, the risk around cyber security and the rationale for introducing a Corporate Risk Register and these were responded to. It was noted that future reports to the Committee would provide more detail on the Corporate Risk Register. The detailed review underway would also enable a more structured focus to understand the arrangements and processes in place with a view to informing discussion, considering the risk appetite of the organisation to try and manage down the level of risks.

Discussion also took place around the connections and linkages between directions from the Integration Joint Board and the resulting impact on the NHS Fife risk profile. As Chief Internal Auditor of the IJB from April 2021, Mr Gaskin assured Members that one of the key areas of his work in that sphere would be on the IJB Risk Management Strategy, which should reflect the relationship of the IJB as a commissioning body and NHS Fife as a delivery body.

The Committee **noted** the report and **noted** the developments on the key risk ratings.

8.2. Risk Management Key Performance Indicators (KPIs)

Mrs Cummings spoke to the update report on performance since the previous report in January 2021 and referred Members to Appendix 1, which provided an assessment of compliance against the KPIs. These are in place and are used to measure if the organisation is on track to meet its objectives. There are currently seven indicators within this dashboard.

Work on the KPIs would be further developed, given the increased focus on the risk management agenda, and a key part of that work will be to engage more with the services. Attention was drawn to section 2.3 of the covering SBAR and the improvement actions agreed in response to the Adverse Event Management audit. An update report would be provided to a future committee meeting.

The Committee **noted** the report.

8.3. Update on Risk Management Workplan 2020/21

The paper provided the Committee with an update on progress against the NHS Fife Risk Management Workplan 2020/21.

The Committee **noted** the delivery of the Workplan 2020/21 and thanked Mrs Cumming for her input.

9. OTHER

9.1. Issues for Escalation to NHS Board

There were no issues to highlight to the Board.

10. ANY OTHER BUSINESS

None.

Date of Next Meeting: 17 June 2021 at 2pm via MS Teams

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2021-22

	Title	Action	Lead	Outcome
1	Service Auditor Reports on Third Party Services	Mrs McGurk suggested that an update should be provided to the NHS Fife Audit & Risk Committee in March 2021, to give assurance that the plan is progressing. It was agreed that this request should be made by the Director of Finance for the March 2021 meeting.	MM	NSS DOF advised that Practitioner Services has been working to redesign the control framework for these areas to ensure all recommendations and actions from the 2019-20 report have been incorporated and delivered. The 2020/21 audit report will confirm the level of progress in-year.
2	Committee Annual Workplan 2021/22	Ms Fraser asked that the workplan be updated under the Annual Accounts section to include the ISA260 report to those charged with governance, and this was agreed	GM	Workplan amended.

Completed Updated

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Draft Audit & Risk Committee Annual Statement of Assurance 2020-21**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance. The Audit & Risk Committee is invited to review the draft of this year's report and comment on its revised content, with a view to considering a final paper at the Committee's meeting in September.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year, as per the Committee's workplan. There are some areas within the Statement for which content cannot as yet be provided (largely with Section 4), as the Committee has not yet formally reviewed the assurance statements from the Board's other governance committees and the IJB, which help to inform any areas of potential disclosure in the final Governance Statement.

Each Board Committee has reviewed their respective draft statements at their meetings in April / May and comments received at those meeting will help inform the final versions that

come to Audit & Risk in September. The majority of Committees have now agreed their statements at the last cycle of meetings, with only Clinical Governance Committee to formally agree a final draft at their next meeting in July (the Chair has, however, approved the current draft, which has extended sections within on HAI inspections and risks considered during the year). Indicative content to reflect these Committee annual assurance statements has been provided in Section 4.8 and this will be finalised after the Clinical Governance Committee has agreed their report. For Section 4.9, the IJB assurance statement will be considered by their Audit & Risk Committee in early June and will be provided to us shortly thereafter, thus content for this section remains to be written.

Given the extended timeframe for approval of the accounts this year, amendments can be discussed and recommended and a final version brought back to Committee for formal approval with the accounts in September.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2020-21, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in providing appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and the Director of Finance & Strategy and takes account of any initial comments thus received. The Committee also reviewed an earlier draft at their meeting in May.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2020/21

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2021, membership of the Audit & Risk Committee comprised:

Martin Black	Chair / Non-Executive Member
Sinead Braiden	Non-Executive Member
Cllr David Graham	Stakeholder Member
Aileen Lawrie	Area Clinical Forum Representative (from March 2021)
Katy Miller	Non-Executive Member (until November 2020)
Janette Owens	Area Clinical Forum Representative (until January 2021)

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Board Chief Executive, Director of Finance & Strategy, Director of Nursing (as the Executive lead for risk), Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the year to 31 March 2021, on the undernoted dates:

- 18 June 2020
- 13 July 2020
- 17 September 2020
- 19 November 2020
- 19 January 2021
- 18 March 2021

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs in late March 2020 (the NHS in Scotland has remained on

an Emergency Footing continually since that date). At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

4.2 Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. Committee meetings largely resumed on their regular schedule from July 2020 onwards, though the normal timeline for the approval of the Board's Annual Accounts was delayed by five months. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan has however been reviewed to ensure that new items related to Covid-19 are covered appropriately and that the required assurances can still be provided to the Board as part of the year-end process. Each Committee has also actively considered a governance checklist, prepared initially by Internal Audit and recommended by the Audit & Risk Committee for adoption by all standing committees, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The range of business covered at meetings held throughout the year, as detailed below, demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control frameworks and arrangements;
- Internal & External Audit planning and reporting;
- Corporate Governance, including implementation of and compliance with the NHSScotland *Blueprint for Good Governance*;
- Updates to the NHS Fife Code of Corporate Governance;
- Scrutiny of the Board's Annual Statutory Financial Statements including the Governance Statement;
- Risk Management arrangements and reporting, including the Board Assurance Framework; and
- other relevant matters arising during the year.

4.4 The Audit & Risk Committee's first meeting of the 2020-21 reporting year took place in June 2020, where a briefing was given on the changes made to the Board's usual governance arrangements and structures in consequence of Covid-19. The report included detail on the Gold / Silver / Bronze Command groups set up to manage the day-to-day response to the pandemic, including how this structure enhanced agile operational decision-making to support a rapid response to the increase in clinical activity, and detailing also the reporting routes to established groups that provide formal assurance to the Board. Also considered was a briefing from Audit Scotland on the potential impact of the pandemic on their audit approach for financial year 2019/20, changes to the usual reporting timelines for the annual accounts, and their phased approach to future audit work.

4.5 The Committee also considered a report providing members with appropriate assurance that there was a robust structure and process in place for the reporting, review and management of Covid-19 related risks. This noted that the process for identifying, reviewing and monitoring risks was well established within the organisational Command structure, with a template and reporting schedule in place for the Bronze and Silver Commands to review and update all risks in Datix. A

fortnightly report on the high level risks identified by these groups was considered by Gold Command on a fortnightly basis. Many of the Covid-related risks were not Board-specific but relate to national risks common across the health sector, as NHS Scotland as a whole responded to the pandemic. Members noted the intention to mainstream the Covid-related risks into the existing Board Assurance Framework on a long-term basis where appropriate.

4.6 In relation to the Annual Accounts process for 2019-20, as the year began it became apparent that the local capacity and capability within the Finance Directorate to deliver the annual statutory accounts was limited, principally as a result of the departure of two key members of the financial services team. Arrangements were put in place to deliver support from NHS Grampian and NHS Lothian. However, the annual accounts draft submission timeline was significantly delayed as a consequence. The final audit process was concluded in November 2020 and no significant audit issues were raised. Nevertheless, it has been critical to address the capacity issues as quickly as possible. Recruitment commenced for a new Head of Financial Services and an appointment made in December 2020. The new Head of Financial Services commenced employment in March 2021, which the Committee note will support planning and preparations for the 2020-21 annual accounts and audit process.

4.7 In reference to External Audit, the Committee has considered in detail the annual audit plan and the annual audit report. The annual audit report includes a report to those charged with governance on matters arising for the audit of the annual financial statements, as well as comment on financial sustainability, governance and best value. The Committee has also considered national reviews undertaken by Audit Scotland, including their report 'NHS in Scotland 2020', and its implications locally. The Committee has also approved the planning memorandum for both the Endowment Funds and Patients' Private Funds from the respective External Auditor.

4.8 For assurance purposes, the Audit & Risk Committee has considered the annual assurance statements of each of the governance committees of the Board, namely: Clinical Governance Committee; Finance, Performance & Resources Committee; Remuneration Committee; and Staff Governance Committee. These detail the activity of each committee during the year, the business they have considered in discharging their respective remits and an outline of what assurance the Board can take on key matters delegated to them. No significant issues were identified from these reports for disclosure in the financial statements, as per the related content of the Governance Statement. Each individual assurance statement has appropriately reflected the impact of Covid-19 on the respective Committee's workplans and usual schedule of business, noting the need to prioritise key risk areas during the year and to ensure that members were apprised in particular of activity aimed at addressing the operational pressures and challenges of Covid, especially during resurgent periods of infection. Appropriate assurance has however been provided that each Committee has fulfilled their key remit areas on behalf of the Board during the reporting year. Use of a checklist provided initially by Internal Audit, to ensure appropriate coverage of key risks, has helpfully informed agenda planning. The Clinical Governance Committee report has provided an enhanced level of information on progress in improving controls around information governance and security, reflecting the expanded content of the assurance reporting template from the Committee's three sub-groups. Further detail has also been provided on the various external inspections carried out within the Board, including those by the Health & Safety Executive and Health Improvement Scotland, each of which had a focus on infection prevention and correct usage of PPE in light of Covid risks. The Finance, Performance & Resources Committee has closely monitored the position in relation to the uncertainty in-year of the impact on expenditure and availability of national funding to support the additional costs associated with the pandemic, and has considered also the impact of Covid on key performance targets. The Staff Governance Committee has received regular updates on the mobilisation of workforce and recruitment to support key programmes, such as Test & Protect and Covid vaccination delivery, in addition to ongoing detail on staff well-being initiatives, such as the dedicated support hubs in operation across a number of sites. The Remuneration Committee has continued its work during the pandemic period, reflecting within its workplan key directives from

the Scottish Government related to remuneration, discretionary points and overtime arrangements, in addition to completing its usual business of performance appraisal and Executive cohort objective setting. Further detail on all these areas can be found within the individual Committee reports mentioned above.

4.9 (*Text TBC*) *In reference to the assurance statement received from the Integration Joint Board, …*

4.10 In relation to internal audit, members have reviewed and discussed in detail at meetings the annual audit plans; the interim evaluation of the internal control framework; reports from the internal auditors covering a range of service areas; and management's progress in completing audit actions raised. A specific progress update from the Clinical Governance Committee, in reference to addressing the recommendations from the Internal Audit review of Adverse Events, was given to members in September 2020, to provide assurance that prompt action was being taken to complete the work required. Across a number of separate reports, Internal Audit have flagged the need for NHS Fife to improve the governance, control framework and assurance processes in place related to Information Governance & Security, and work to address these recommendations has been significantly advanced in the year of reporting. Reporting on compliance with the control framework has now been developed and will be embedded in practice during 2021-22. A review of current transformation programmes will be encompassed within the overall development of a new Health & Well-Being Strategy for Fife, which will succeed the current Clinical Strategy. The Committee looks forward to receiving the assessment of Internal Audit on these developments in due course.

4.11 In relation to internal audit follow-up work, whilst improvements in reducing the number of outstanding actions has been seen in this reporting year, the Committee has noted that further effort is required to enhance the effectiveness and timeliness of completing audit recommendations. The Director of Finance & Strategy has undertaken to improve this as a priority action, with quarterly consideration of the outstanding actions by the Executive Directors' Group to drive forward prompt resolution.

4.12 On behalf of the Board, the Audit & Risk Committee receives regular updates on the workstreams being progressed within NHS Fife for compliance with the NHSScotland *Blueprint for Good* Governance, including the national work ongoing to develop a suite of standard documentation on a 'Once for Scotland' approach. Whilst many of the national workstreams have been delayed due to the impact of the pandemic on NHSScotland, the Committee has received an update on the Board's Blueprint action plan at its September 2020 meeting. A number of the outstanding actions have been completed, and progress with the remainder was reported within, in tandem with revised target dates for completion. The Board's own Code of Corporate Governance has undergone annual review and a number of clarifying changes made, to ensure it remains up-to-date with current practice.

4.13 During the year, members of the Committee have engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. A discussion session with the Internal and External Auditors was held in March 2020, outlining the year-end processes each undertake as part of the review of the financial statements and systems of internal control, in preparation for the review of the annual accounts. A follow-up training session by Audit Scotland, covering the annual accounts scrutiny process, was delivered in September 2020, prior to the Committee's formal consideration of the 2019-20 financial statements.

4.14 In January 2021, the Committee received a training and awareness-raising session from Gordon Young, Head of the Counter Fraud Service (CFS) at NHS NSS. Mr Young delivered an informative presentation on the work being undertaken to detect, investigate and prevent fraud, including new activity linked to opportunities for fraud brought about by the Covid pandemic. It has been agreed to make widely available to staff, via the new employee app StaffLink, details from CFS intelligence alerts, to ensure all staff are aware of current scams and frauds that might be perpetrated within NHS Fife.

4.15 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, which provided members with updates on NHS Fife fraud cases, counter fraud training delivered to staff, initiatives undertaken to identify and address fraud, and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. This has provided the Committee with the assurance that the risk of fraud is being managed and addressed across NHS Fife. The Committee has also considered the Annual Report on Patient Exemption Checking, which detailed the work undertaken by CFS in checking the propriety of exemptions claimed by patients for ophthalmic and dental work and summarised the write offs and recoveries for NHS Fife.

4.16 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2020/21.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

6.2 All of the key areas within the organisation maintain a risk register. All risk registers are held on the Datix (Risk Management Information System). Training and support for all Datix modules including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities and teams etc.

6.3 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF). Progress and appropriate actions were noted, and a number of changes to mitigating and operational risks amended, including those to reflect Covid-related risks. In line with assurance mapping principles, the Digital & Information BAF has been reviewed and updated by the former General Manager for Digital & Information, in collaboration with Internal Audit and the Risk Manager. Approval of the revised version through the internal governance routes is underway. The Quality & Safety BAF is scheduled for review as part of Audit B19/21 in line with assurance mapping principles, and this will include an assessment of whether the risk has been appropriately updated to take account of the full impact of Covid-19.

6.4 The Committee received updates on activity related to the risk management workplan during the year, including reports on a suite of key performance indicators. The Risk Framework was updated in September 2020 to incorporate the approach to risk management within the organisation, detailing the responsibilities for managing risks and processes for effective risk management. The Board's approach to risk appetite / tolerance has been outlined therein, as are the appropriate governance structures that are in place to ensure that the relevant committees are aware of the risks that are in our system.

6.5 The revised arrangements relating to the Corporate Risk Register require to be finalised. This register will be subject to a high level Internal Audit review in the coming months. The Board initially agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by November 2020, though this activity was delayed due to competing priorities arising from the coronavirus pandemic. Further work is required to update and agree a risk appetite statement that states the type, and level of risks to be eliminated, tolerated or managed based on an assessment of the balance of risk versus reward. The review will take place in Q3 of 2021.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its May 2021 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2020/21, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed: _____ Date: _____

Martin Black, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE - ATTENDANCE RECORD 2020/21

	18.06.20	13.07.20	17.09.20	19.11.20	19.01.21	18.03.20
Members						
M Black	✓	✓	✓	✓	✓	✓
S Braiden	✓	✓	✓	✓	✓	✓
Cllr D Graham	x	✓	x	x	✓	✓
A Lawrie						✓
K Miller	✓	✓	✓	✓		
J Owens	✓	✓	✓	✓		
In attendance						
C Potter, Chief Executive	✓	✓	✓	✓	✓	✓
M McGurk, Director of Finance & Strategy	✓	✓	✓	✓	✓	✓
H Buchanan, Director of Nursing	✓	x	✓	x	✓	
J Owens, Director of Nursing					✓	x
G MacIntosh, Board Secretary	✓	✓	✓	✓	✓	✓
K Booth, Head of Financial Services						✓
T Gaskin, Chief Internal Auditor	✓	✓	✓	✓	✓	✓
B Hudson, Regional Audit Manager, Fife	✓	✓	✓	✓	✓	✓
P Fraser, Audit Scotland	✓	✓	✓	✓		✓
P Cummings, Risk Manager		✓				
A Clyne, Audit Scotland			✓	✓		✓
B Howarth, Audit Scotland			✓			
L Donovan, eHealth General Manager		✓				
R Mackinnon, Ass. Director of Finance			✓			
A Mitchell, Thomson Cooper (Annual Accounts Endowments)				✓		
S Slayford, Principal Auditor					✓	
R Robertson, Deputy Director of Finance				✓		
C Leith, Financial Planning, Projects & Costing Accountant				✓		
O Notman, Head of Financial Control, NHS Lothian				✓		
G Young, Head of Counter Fraud Service, NSS					✓	

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Board Assurance Framework (to FP&R/CG/SG Committees) Board Assurance Framework (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation's activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	On going	Meetings publicly accessible NHS website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual Annual Ongoing	Code of Corporate Governance review Annual Assurance statements Compliance with NHS Scotland Blueprint

USE OF RESOURCES

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts Assurance Statements SFIs
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term. The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The “Equality” theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife’s policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA forms on reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Draft Governance Statement**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Head of Corporate Governance & Board Secretary**

1 Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

As Accountable Officers, Chief Executives are responsible for maintaining sound systems of internal control. Chief Executives must prepare a Governance Statement that complies with guidance in the Scottish Public Finance Manual (SPFM), which is accurate, complete, and fairly reports the known facts.

2.2 Background

For 2020/21, there have been no substantial changes made to the Governance Statement format or guidance, as set out within the NHS Scotland Annual Accounts Manual. However, there are a number of areas which merit consideration in the Governance Statement for 2020/21. These include:

- appropriately reflecting the impact of Covid-19 on the Board's governance arrangements during the year, reflecting the fact that the Board has worked under Scottish Government direction for the full reporting year;
- a section outlining the new Strategic Planning & Resource Allocation process, including the Remobilisation Planning work undertaken in-year;

- commentary on enhanced Information Governance & Security governance arrangements, given internal audit's focus on this in last year's report and within their interim assessment of the control environment carried out mid-year; and
- recognition of the fact that work on revising the Fife Integration Scheme remains in progress at the time of writing.

2.3 Assessment

A fundamental part the Accountable Officer's responsibility is to manage and control all the available resources used in his or her organisation. The Governance Statement is a key feature of the annual report / accounts and provides commentary on how these duties have been carried out in the course of the year, including aspects of corporate governance and risk management.

As part of the overall governance and assurance processes of the Board, both the Chief Internal Auditor and the Board's External Auditor (currently Audit Scotland) are required to provide an annual report within the dimensions of their respective remits. In providing the Internal Audit Annual report, the Chief Internal Auditor specifically reviews the Governance Statement for:

- consistency with information the internal audit team are aware of from their own work;
- accurate and appropriate description of processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected within;
- that the format and content of the Governance Statement are compliant with relevant guidance; and
- disclosure of all relevant issues.

2.3.1 Quality / Patient Care

Good governance is a central pillar in enhancing quality standards and improving patient care.

2.3.2 Workforce

The Draft Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Draft Governance Statement reflects the control environment supporting financial governance.

2.3.4 Risk Assessment / Management

The Draft Governance Statement reflects the effectiveness of risk management arrangements operating across the organisation. Further information is contained with the Risk Management Annual Report, given as a separate agenda item to this meeting.

2.3.5 Equality and Diversity, including health inequalities

No specific issues to report regarding equality and diversity.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders (such as the auditors and Scottish Government colleagues) was conducted in the preparation of the paper.

2.3.8 Route to the Meeting

The Draft Governance Statement has been considered by the Executive Directors' Group at their meeting on 10 June.

2.4 Recommendation

The paper is provided for: **Approval**. The Committee is invited to review the draft Governance Statement as attached and provide any comments as required.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Draft Governance Statement (submitted in draft to Audit Scotland and Internal Audit on 1 June 2021)

Report Contact
Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Fife Health Board Endowment Fund, re-branded in the reporting year to the Fife Health Charity. This statement includes any relevant disclosure in respect of these Endowment funds.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise, and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively, and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary, and administrative requirements, emphasises the need for efficiency, effectiveness, and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on page 16, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties. In response to the pandemic during 2020/21, changes were made to the format and timing of governance meetings as detailed in the *Covid-19 Pandemic – Governance Arrangements* section on page 26.

These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration; and
- Finance, Performance & Resources.

Clinical Governance Committee

Principal Function:
To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities, including health improvement activities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board

- Chief Executive
- Medical Director
- Director of Nursing
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

Chair:
Dr Les Bisset, Non-Executive Board Member (Until 31.03.21)

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit & Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Martin Black, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

Principal Function:
To support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

Membership:
- Four Non-Executive Members of the Board
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Margaret Wells, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times a year.

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:

- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Chief Executive
- Employee Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

Frequency of Meetings:
As necessary to fulfil its remit but not less than three times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Director of Public Health

Chair:
Rona Laing, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new national Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance, and to improve consistency across NHS Boards using this 'Once for Scotland' approach.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the NHS Board's annual review of governance arrangements. The annual review also covers the remits of the NHS Board's Standing Committees and a self-assessment of each Committee's effectiveness.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and assurances provided, Best Value, risk management and to demonstrate they have fully fulfilled their roles and remit. The format and content of these reports have been further improved in the current year, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been created to ensure consistency.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available.

Ongoing work to improve Board effectiveness builds on the proposals originally approved by the Board in 2017 and 2018, in relation to the Chair's review of governance arrangements in NHS Fife. It also reflects the requirements of the NHS Scotland Blueprint for Good Governance (https://learn.nes.nhs.scot/28418/board-development/blueprint-for-good-governance), which is presently being implemented across all Boards. In mapping the Board's arrangements for governance against the standards given in the national Blueprint,

detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made. A recent internal audit review has been undertaken of NHS Fife's compliance with the Blueprint, with the conclusion that 'comprehensive assurance' can be taken from the implementation work progressed thus far. Whilst national work aimed at developing the individual workstreams from the Blueprint was largely paused in 2020/21, due to the pressures of the pandemic, activity is expected to increase, with the Board due to take part in the roll-out of the Active Governance component from autumn 2021.

During 2019, Board members were each invited to complete a diagnostic self-assessment questionnaire assessing the Board against the Blueprint's initial requirements, to identify common themes and areas for improved effectiveness at Board-level. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and, following discussion, an action plan was approved at the May 2019 Board meeting. A progress update was considered by the Board in November 2019 and, following thereon, a further iteration presented in September 2020. A summary of the most recent self-assessment process, noting the largely positive evaluation of governance arrangements in place in NHS Fife, can be found at the link below: https://nhsfife.org/media/35026/blueprintupdatesept20.pdf

Each year, Board committees also undertake a detailed self-assessment exercise, via the format of an online questionnaire. Response rates frequently reach 100% of members and attendees, though participation in this reporting year was reduced due to the timing of the survey occurring within the second wave of the pandemic. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is a central part of the internal year-end assurance process.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-Executive Directors have a supported orientation to the organisation, as well as a series of development sessions. An enhanced induction programme has been established to support new members and a dedicated Induction Pack is update on a rolling basis. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an example of best practice. Opportunities for ongoing member support also exist at a national level via the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development) and related resources, and discussions around individual member development are a key part of the annual appraisal process of each member by the Chair.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD), internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. A dedicated Covid-19 log has operated throughout the current year to capture and track all relevant correspondence. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees support the Board in delivering best value through the relevant focus within their Terms of Reference and the annual work-plans. Directors and Managers are encouraged to review, identify, and improve the efficient and effective use of resources.

During 2020/21, NHS Fife had a Whistleblowing policy in place. A dedicated Whistleblowing Champion, Katy Miller, took up position on the Board as a full Non-Executive Member in February 2020, though she resigned from that post, due to her work commitments, in November 2020. A national-led recruitment process for a successor has successfully concluded and Kirstie Macdonald has joined the Board in that role from 1 April 2021. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards that have been rolled out across all NHS Boards from April 2021 and is assured that adequate preparations are in place for their adoption. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, managed under the Board's Management of Employee Conduct policy.

There is a well-established complaints system in place whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage, and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to engage with them on our plans and performance.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The impact of Covid-19 on performance against key metrics has been significant and the Board notes the challenges to be faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee from its own review of the IPQR.

In relation to initial challenges faced by NHS Fife around its annual programme of Seasonal Flu Immunisation, the Board had initially recognised that the 2020/21 campaign was expected to be more challenging than previous years, due to the ongoing restrictions of the pandemic, and with a different model of delivery from the previous GP-led clinics. On the programme's launch in mid-September 2020, the increased demand for flu vaccinations quickly overwhelmed the planned delivery model and communications hub, resulting in a less than satisfactory patient experience and reputational damage to the Board. An independent review into the seasonal flu programme was commissioned in October 2020 and a 'Lessons Learned' report considered in depth by Clinical Governance Committee and the Board at their meetings in November. The report made a number of important recommendations in the areas of governance, reporting routes and clarity of roles and responsibilities; dedicated planning and project management support; workforce; communications; and IT support. A related Action Plan was developed, and regular reporting on addressing these individual improvement actions has continued. In addition, an external review was commissioned to consider how the Board delivers immunisation programmes in general (noting the additional activity in this area due to Covid-19), and in particular clarifying the respective responsibilities for Public Health and colleagues in the Fife Health & Social Care Partnership. The recommendations of this review will be taken forward during 2021/22.

Robust action plans were developed following Health Improvement Scotland (HIS) external inspection visits to Glenrothes Hospital (on 7-8 July 2020) and to Adamson Hospital (28 October 2020).

The Glenrothes Hospital inspection report is available at:
http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/glenrothes_hospital_sep_20.aspx) resulted in the identification of four areas of good practice (particularly in the areas of hospital cleanliness and infection control support) and five requirements for improvement (one concerning the condition of equipment and the remainder to improving documentation to ensure that patient health and wellbeing were being appropriately supported and safeguarded).

The Adamson Hospital inspection report is available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/adamson_hospital_jan_21.aspx) highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improving documentation to ensure that patient health and wellbeing were being supported and safeguarded and two requirements were in relation to infection control practices helping support a safe environment for patients and staff. At their May 2021 meeting, the Clinical Governance Committee was pleased to note that the action plan in relation to the Glenrothes Hospital inspection had been fully completed, and that the Adamson Hospital action plan was well advanced towards full completion.

During 2020/21 the Board, as the Corporate Trustee for the Fife Health Charity, kept under review the overall governance for charitable funds, including the approach to the management and oversight of funds.

Integration Joint Board (IJB)

A number of NHS Fife Board Members also have a role on the Integration Joint Board and its Committees and maintain responsibility for their respective professional remits at all times. The Director of Health & Social Care as the Accountable Officer for the IJB is also a direct report to the NHS Fife Chief Executive. The Chief Executive maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB, and the IJB's Clinical & Care Governance Committee, are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also provided from the IJB's Chief Internal Auditor and the IJB's Clinical & Care Governance Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2020/21 the NHS Board and supporting governance committees maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB will continue to be developed during 2021/22 to ensure clarity and consistency of approach.

A joint review of the Fife Integration Scheme was originally scheduled to conclude by 31 March 2020 (as per the five-year review cycle required by legislation). This review was paused due to the onset of the Covid-19 pandemic. Changes to the current Scheme were agreed by the March 2020 date; however, a number of areas (including the risk share arrangement) required further consideration. A proposal to vary the risk share arrangement was discussed and the matter was then submitted to both Chief Executives of NHS Fife and Fife for consideration. Until a revised Scheme is agreed, the extant Scheme remains in force. Due to the circumstances of the pandemic, Scottish Government has indicated they are content that a local review is concluded by the statutory deadline and an indicative timescale provided on when any additional outstanding issues will be formally concluded. A letter was sent to Scottish Government which confirmed the completion of the local review and provided a timescale of 30 June 2021 for the conclusion of arrangements for the risk share within the new Scheme.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with Executive Directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- Letters of Assurance from each Director;
- Reports from other inspection bodies;
- The work of the internal auditors, who submit to the Audit & Risk Committee regular reports, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- Comments by the external auditors in their management letters and other reports;
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees;
- The range of topics covered at Board Development Sessions, to develop the knowledge and awareness of both Executive and Non-Executive Board members;
- The Board's agreed approach to Risk Management established within the Governance Committees;
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, and the Clinical Governance Committee (which also embraces Information Governance & Security);

Data Quality

The Board receives a range of reports which include financial, clinical, and staffing information. In general, these reports are considered by the Executive Directors Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration and scrutiny of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (through the Information Governance & Security Steering Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies.

Risk Management

The Chief Executive of the NHS Board as Accountable Officer, whilst personally answerable to Parliament, is ultimately also accountable to the Board for the effective management of risk.

NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for an effective risk management strategy are set out in the SPFM.

All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix, the Risk Management Information System. Training and support for all Datix modules, including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities, and teams.

During 2020/21, the high level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high level risks, were reported as part of the Board Assurance Framework (BAF), to the governance committees on a bi-monthly basis, and thereafter to the Audit & Risk Committee and the Board.

Work is ongoing to review the Board's risk management arrangements, to ensure they continue to reflect good practice.

The Board agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by November 2020. This activity was delayed due to competing priorities arising from the pandemic. Further work is required to update and agree a risk appetite statement that states the type and level of risks to be eliminated, tolerated, or managed based on an assessment of the balance of risk versus reward. The review will take place in Q3 of 2020/21. This will involve consideration of the risk appetite of the Board in relation to both operational delivery and performance and strategy.

Performance against Risk Management Key Performance Indicators (KPIs) were reported to the Audit & Risk Committee during 2020/21.The adverse event components of the KPIs are reported to the NHS Fife Adverse Events & Duty of Candour Group, which reports through the Board's Clinical Governance structures. Further consideration will be given to KPI reporting to the NHS Fife Clinical Governance Committee.

The areas for development identified above will all be captured in the updated Risk Management Framework.

During 2020/21, the Director of Nursing, as Executive Lead for Risk Management, reported on all of the above to the Audit & Risk Committee.

Strategy Development and Strategic Planning and Resource Allocation

During 2020/21 the Board introduced a new Strategic Planning and Resource Allocation (SPRA) process. This is an annual process that details how each directorate/programme supports the delivery of the overall organisational strategy. The new process informed the development of the Operational Plan (RMP3) for 2021/22. Through this process, Directorate positions were consolidated, and investments and disinvestments prioritised to deliver the most effective allocation of resources. The prioritisation was influenced by the Scottish Government policy objectives and the recurring impact of Covid-19. The prioritisation process also reflected that the NHS in Scotland will operate under the direction of the Scottish Government at least until the end of June 2021.

The SPRA process creates a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the medium-term financial plan and long-term strategic plan for NHS Fife.

Information Governance and Security

The Internal Audit Annual Report 2019/20 highlighted that assurance on the effectiveness of the Board Information Governance arrangements could be improved in some areas. During 2020/21 there was a key focus on delivering improvements to this important area of governance. As a result of the work undertaken, there has been an improvement in the effectiveness of our governance arrangements including enhancing the necessary processes and controls to provide a baseline of consistent and reliable assurance. Additionally, reporting on compliance with the control's framework has been developed and will be embedded in practice during 2021/22. There were no material deteriorations in levels of compliance against controls during 2020/21; indeed, several areas noted improved performance, including a reduction in the number of potential personal data related incidents or data protection breaches reported to the Information Commissioner (ICO), as detailed on p.17. A number of areas require further work to ensure consistent improvement and a plan has been established to target improvements in compliance where that is required, this will be continuously monitored during 2021/22.

Covid-19 Pandemic – Governance Arrangements

The business of the Board during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs on 25 March 2020 (the NHS in Scotland has remained on an Emergency Footing continually since that date). Individual NHS Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive; NHS Fife returned their own submission on 30 March 2020. At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

Since the outbreak of the pandemic in mid-March 2020, the Board has continued to hold its bi-monthly meetings remotely, utilising videoconferencing via MS Teams, with a prioritised agenda in place for each Board meeting. Whilst it has not been possible to meet physically in a public setting due to the ongoing lockdown restrictions and social distancing measures, from the May 2020 Board meeting onwards, representatives from the local media were invited to listen in via Teams. Arrangements for members of the public to join virtual meetings have also been in place since shortly after that date, with NHS Fife one of the first Boards to establish a process for remote public access. Board papers continue to be published in advance on the NHS Fife website, as do the Board minutes after each meeting has taken place.

Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. As per the letter from Richard McCallum, Director of Health Finance and Governance of 11 June 2020, prior notification of the intention to resume Committee meetings, and the rationale for that, was given by the Board to Scottish Government. Committee meetings largely resumed on their regular schedule from July 2020 onwards. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan was however reviewed to ensure that new items related to Covid-19 were covered appropriately and that the required assurances could be provided to the Board as part of the year-end process. Each Committee also actively considered a governance checklist, prepared initially by Internal Audit and recommended by the Audit & Risk Committee for adoption by all standing committees, to help enhance agenda planning and ensure that no areas of risk were overlooked.

During the height of the pandemic, in both the first and second waves of Covid-19 related activity, weekly meetings of the Chair, Vice-Chair and members of the Executive Team were held, with a detailed note circulated to Board members for their information. The Chair and Vice-Chair additionally had regular contact with the Chief Executive and other key members of the Executive Team on priority items as and when required. Regular meetings with local elected representatives (MPs/MSPs) also continued to operate on a monthly basis.

During both the first and second waves of the pandemic, NHS Fife established an organisational command structure to provide direction, decision-making, escalation, and communication functions during the busiest

times of activity. Initially, from late March 2020, meetings of Gold Command were scheduled daily. By the end of June this was reduced this to weekly as a result of the reduction in Covid-19 related activity and reporting from its supporting Silver and Bronze groups. Routine meetings such as the weekly meeting of the Executive Team, and a formal Executive Directors' Group (EDG) meeting, were resumed in June. Gold Command - and its supporting structures below - stood up once again on a weekly basis, from September 2020 to the end of March 2021, to manage the second wave of the Covid-19 pandemic. The organisational structure utilised successfully in the first two phases of the pandemic will be re-introduced, should future circumstances require.

Disclosures

During the 2020/21 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Scottish Government Portfolio Audit & Risk Committee: Significant Issues that are considered to be of wider interest**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition:

- Effective

2 Report summary

2.1 Situation

The Audit & Risk Committee of NHS Fife has a responsibility to ensure any significant issues that are considered to be of wider interest are brought to the attention of the Scottish Government Portfolio Audit & Risk Committee.

2.2 Background

This is an annual return made by all NHS Board Audit & Risk Committees and follows the agreed format as detailed in the Scottish Public Finance Manual (SPFM) and the letter from the Health Finance Directorate dated 30 April 2021 (Appendix 1). The report is informed by the assurances received to support the Accountable Officer's Annual Governance Statement, note this is in draft until the Statutory Annual Accounts for 2020/21 are finalised through the external audit process. Two Guidance Notes were issued in March – April 2020 to ensure changes to internal Board governance processes, as a result of Covid-19, were appropriately reflected in the significant issues return letter.

2.3 Assessment

The draft response letter is presented in Appendix 2 with the Governance Statement as a supporting document.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Governance Statement reflects the control environment supporting financial governance.

2.3.4 Risk Assessment/Management

The Governance Statement reflects the effectiveness of risk management arrangements operating across the organisation.

2.3.5 Equality and Diversity, including health inequalities

No specific issue to report.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Relevant communication and consultation within the organisation were conducted in preparation of the draft response.

2.3.8 Route to the Meeting

A draft of the response letter was approved by Margo McGurk for discussion at the Audit & Risk Committee.

2.4 Recommendation

The paper is provided for Approval.

The Committee is invited to review the letter and the draft Governance Statement to inform approval of the response to Scottish Government.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Letter dated 30 April 2021 from Director of Health Finance Governance, Richard McCallum
- Appendix 2 – Draft Response Letter dated 17 June 2021 from Martin Black, Chair of NHS Fife Audit & Risk Committee

Report Contact
Margo McGurk
Director of Finance & Strategy
Email Margo.mcgurk@nhs.scot

Health Finance, Corporate Governance & Value Directorate
Richard McCallum, Director

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Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS Board Chairs
Mental Welfare Commission Chair

Copied to:
NHS Board Chief Executives
NHS Board Directors of Finance
Mental Welfare Commission Chief Executive

30 April 2021

Dear Chair

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

The guidance in the Scottish Public Finance Manual (SPFM) requires Audit Committees of NHS Scotland Boards to notify the relevant Scottish Government Portfolio Audit and Risk Committee,of any significant issues that are considered to be of wider interest.

https://www.gov.scot/publications/scottish-public-finance-manual/audit-committees/audit-committees/

The Chair of your Board's Audit Committee should provide details of any significant issues of fraud which arose during 2020-21 which they consider should be brought to the attention of the Health and Social Care Assurance Board.

This should be informed by the assurances received to support the Governance Statement in your Board's Annual Accounts and it is therefore appropriate for the Audit Committee to consider this statement at the same time as the Accounts and the Governance Statement.

Audit committees have a role in providing the assurance required to underpin the governance statement provided by the Principal Accountable Officer (the Scottish Government Permanent Secretary) as part of the consolidated accounts of the Scottish Government. Your Board's Audit Committee is therefore required, at the earliest opportunity, to notify the Health and Social Care Assurance Board if it considers that it has identified a significant problem which may have wider implications. The Health and Social Care Assurance Board will in turn report relevant issues to the Scottish Government Assurance and Audit Committee.

COVID-19 – revised guidance

Two Finance Guidance Notes (FGNs) have been issued by Scottish Government and should be read alongside the SPFM to ensure that changes to internal processes, as a result of COVID-19, are appropriately reflected in 2020-21 significant issues letters and Governance Statements.

FGN2020/03	COVID-19 Accountable Officer Guidance and Funding Ask Template	March 2020
FGN2020/04	COVID-19 - short-term changes to approval process for operational property transactions	April 2020

In addition, Boards should refer to:

- my letter of 20 March 2020 (and subsequent correspondence) on Mobilisation Plans; and
- my letters of 25 March and 11 June 2020 (as appropriate) requesting detail on temporary changes to governance and the rationale for these changes.

All statements **including a copy of the governance statement** should be submitted by **30 June 2021**, to nhsaccounts@gov.scot.

Please do not hesitate to contact Pawel Kurcz (Pawel.Kurcz@gov.scot) if you require further information.

Yours faithfully

Richard McCallum
Director of Health Finance and Governance

Fife NHS Board

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Richard McCallum
Director of Health Finance and Governance
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Date	3 June 2021
Your Ref	
Our Ref	RM/Martin Black/
Enquiries to	Mrs M McGurk
Extension	Ext 28139
Direct Line	01592 648139
Email	margo.mcgurk@nhs.scot

Dear Mr McCallum

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

I refer to your letter dated 30 April 2021, addressed to the Chair of Fife NHS Board. As Chair of the Audit and Risk Committee, I have considered this letter and attach the draft Governance Statement (Annex 1) for 2020/21 to support my response. The Governance Statement details the necessary revisions to NHS Fife Board governance arrangements during the pandemic period and I can confirm the Statement was approved by the Audit and Risk Committee on 17 June 2021.

I can confirm that during the 2020/21 financial year, no other significant control weaknesses or issues arose in relation to the expected standards for good governance, risk management and control.

In relation to your letters of 25 March 2020 and 11 June 2020 requesting detail on temporary changes to governance and the rationale for these changes, I can confirm the following. Further to the information in the Governance Statement and as per the Board's responses to your correspondence, regular meetings of the Board's Governance Committees were reinstated from July 2020. These meetings considered prioritised business relating to COVID-19 and agenda items that otherwise required approval or discussion.

Regarding Finance Guidance Note 2020/04 - COVID-19 and short-term changes to approval process for operational property transactions, the Board did not exercise any right under the COVID-19 guidance concerning property transactions and does not expect to.

In respect of Finance Guidance Note 2020/03 - COVID-19 Accountable Officer Guidance and Funding Ask Template and correspondence/returns around Mobilisation Plans; Local Mobilisation plans including cost information were submitted to Scottish Government in line with the appropriate reporting requirements and timescales.

Fraud and related matters
There have been no significant issues raised in respect of fraud, however I can confirm that updates on fraud/potential fraud cases being investigated by Counter Fraud Services were discussed with NHS Fife and reported to the Audit & Risk Committee at each meeting.

I trust that this letter will meet the reporting requirements. Please do not hesitate to contact myself or Margo McGurk, Director of Finance & Strategy if you require any further information.

Yours sincerely

MARTIN BLACK
Fife NHS Board, Audit & Risk Committee Chair

Annex 1 – Governance Statement

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Fife Health Board Endowment Fund, re-branded in the reporting year to the Fife Health Charity. This statement includes any relevant disclosure in respect of these Endowment funds.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise, and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively, and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary, and administrative requirements, emphasises the need for efficiency, effectiveness, and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on page 16, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties. In response to the pandemic during 2020/21, changes were made to the format and timing of governance meetings as detailed in the *Covid-19 Pandemic – Governance Arrangements* section on page 26.

These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration; and
- Finance, Performance & Resources.

<u>Clinical Governance Committee</u>

Principal Function:
To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities, including health improvement activities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Medical Director
- Director of Nursing
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

Chair:
Dr Les Bisset, Non-Executive Board Member (Until 31.03.21)

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit & Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Martin Black, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

Principal Function:
To support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

Membership:
- Four Non-Executive Members of the Board
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Margaret Wells, Non-Executive Board Member

Frequency of Meetings:

As necessary to fulfil its remit but not less than four times a year.

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:
- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Chief Executive
- Employee Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

Frequency of Meetings:
As necessary to fulfil its remit but not less than three times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Director of Public Health

Chair:
Rona Laing, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new national Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance, and to improve consistency across NHS Boards using this 'Once for Scotland' approach.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the NHS Board's annual review of governance arrangements. The annual review also covers the remits of the NHS Board's Standing Committees and a self-assessment of each Committee's effectiveness.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and assurances provided, Best Value, risk management and to demonstrate they have fully fulfilled their roles and remit. The format and content of these reports have been further

improved in the current year, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been created to ensure consistency.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available.

Ongoing work to improve Board effectiveness builds on the proposals originally approved by the Board in 2017 and 2018, in relation to the Chair's review of governance arrangements in NHS Fife. It also reflects the requirements of the NHS Scotland Blueprint for Good Governance (https://learn.nes.nhs.scot/28418/board-development/blueprint-for-good-governance), which is presently being implemented across all Boards. In mapping the Board's arrangements for governance against the standards given in the national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made. A recent internal audit review has been undertaken of NHS Fife's compliance with the Blueprint, with the conclusion that 'comprehensive assurance' can be taken from the implementation work progressed thus far. Whilst national work aimed at developing the individual workstreams from the Blueprint was largely paused in 2020/21, due to the pressures of the pandemic, activity is expected to increase, with the Board due to take part in the roll-out of the Active Governance component from autumn 2021.

During 2019, Board members were each invited to complete a diagnostic self-assessment questionnaire assessing the Board against the Blueprint's initial requirements, to identify common themes and areas for improved effectiveness at Board-level. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and, following discussion, an action plan was approved at the May 2019 Board meeting. A progress update was considered by the Board in November 2019 and, following thereon, a further iteration presented in September 2020. A summary of the most recent self-assessment process, noting the largely positive evaluation of governance arrangements in place in NHS Fife, can be found at the link below: https://nhsfife.org/media/35026/blueprintupdatesept20.pdf

Each year, Board committees also undertake a detailed self-assessment exercise, via the format of an online questionnaire. Response rates frequently reach 100% of members and attendees, though participation in this reporting year was reduced due to the timing of the survey occurring within the second wave of the pandemic. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is a central part of the internal year-end assurance process.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-Executive Directors have a supported orientation to the organisation, as well as a series of development sessions. An enhanced induction programme has been established to support new members and a dedicated Induction Pack is update on a rolling basis. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an example of best practice. Opportunities for ongoing member support also exist at a national level via the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development) and related resources, and discussions around individual member development are a key part of the annual appraisal process of each member by the Chair.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD), internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. A dedicated Covid-19 log has operated throughout the current year to capture and track all relevant correspondence. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees support the Board in delivering best value through the relevant focus within their Terms of Reference and the annual work-plans. Directors and Managers are encouraged to review, identify, and improve the efficient and effective use of resources.

During 2020/21, NHS Fife had a Whistleblowing policy in place. A dedicated Whistleblowing Champion, Katy Miller, took up position on the Board as a full Non-Executive Member in February 2020, though she resigned from that post, due to her work commitments, in November 2020. A national-led recruitment process for a successor has successfully concluded and Kirstie Macdonald has joined the Board in that role from 1 April 2021. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards that have been rolled out across all NHS Boards from April 2021 and is assured that adequate preparations are in place for their adoption. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, managed under the Board's Management of Employee Conduct policy.

There is a well-established complaints system in place whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage, and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to engage with them on our plans and performance.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The impact of Covid-19 on performance against key metrics has been significant and the Board notes the challenges to be faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee from its own review of the IPQR.

In relation to initial challenges faced by NHS Fife around its annual programme of Seasonal Flu Immunisation, the Board had initially recognised that the 2020/21 campaign was expected to be more challenging than previous years, due to the ongoing restrictions of the pandemic, and with a different model of delivery from the previous GP-led clinics. On the programme's launch in mid-September 2020, the increased demand for flu vaccinations quickly overwhelmed the planned delivery model and communications hub, resulting in a less than satisfactory patient experience and reputational damage to the Board. An independent review into the seasonal flu programme was commissioned in October 2020 and a 'Lessons Learned' report considered in depth by Clinical Governance Committee and the Board at their meetings in November. The report made a number of important recommendations in the areas of governance, reporting routes and clarity of roles and responsibilities; dedicated planning and project management support; workforce; communications; and IT support. A related Action Plan was developed, and regular reporting on addressing these individual improvement actions has continued. In addition, an external review was commissioned to consider how the Board delivers immunisation programmes in general (noting the additional activity in this area due to Covid-19), and in particular clarifying the respective responsibilities for Public Health and colleagues in the Fife Health & Social Care Partnership. The recommendations of this review will be taken forward during 2021/22.

Robust action plans were developed following Health Improvement Scotland (HIS) external inspection visits to Glenrothes Hospital (on 7-8 July 2020) and to Adamson Hospital (28 October 2020).

The Glenrothes Hospital inspection report is available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/glenrothes_hospital_sep_20.aspx) resulted in the identification of four areas of good practice (particularly in the areas of hospital cleanliness and infection control support) and five requirements for improvement (one concerning the condition of equipment and the remainder to improving documentation to ensure that patient health and wellbeing were being appropriately supported and safeguarded).

The Adamson Hospital inspection report is available at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/adamson_hospital_jan_21.aspx) highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improving documentation to ensure that patient health and wellbeing were being supported and safeguarded and two requirements were in relation to infection control practices helping support a safe environment for patients and staff. At their May 2021 meeting, the Clinical Governance Committee was pleased to note that the action plan in relation to the Glenrothes Hospital inspection had been fully completed, and that the Adamson Hospital action plan was well advanced towards full completion.

During 2020/21 the Board, as the Corporate Trustee for the Fife Health Charity, kept under review the overall governance for charitable funds, including the approach to the management and oversight of funds.

Integration Joint Board (IJB)

A number of NHS Fife Board Members also have a role on the Integration Joint Board and its Committees and maintain responsibility for their respective professional remits at all times. The Director of Health & Social Care as the Accountable Officer for the IJB is also a direct report to the NHS Fife Chief Executive. The Chief Executive maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB, and the IJB's Clinical & Care Governance Committee, are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also provided from the IJB's Chief Internal Auditor and the IJB's Clinical & Care Governance Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2020/21 the NHS Board and supporting governance committees maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB will continue to be developed during 2021/22 to ensure clarity and consistency of approach.

A joint review of the Fife Integration Scheme was originally scheduled to conclude by 31 March 2020 (as per the five-year review cycle required by legislation). This review was paused due to the onset of the Covid-19 pandemic. Changes to the current Scheme were agreed by the March 2020 date; however, a number of areas (including the risk share arrangement) required further consideration. A proposal to vary the risk share arrangement was discussed and the matter was then submitted to both Chief Executives of NHS Fife and Fife for consideration. Until a revised Scheme is agreed, the extant Scheme remains in force. Due to the circumstances of the pandemic, Scottish Government has indicated they are content that a local review is concluded by the statutory deadline and an indicative timescale provided on when any additional outstanding issues will be formally concluded. A letter was sent to Scottish Government which confirmed the completion of the local review and provided a timescale of 30 June 2021 for the conclusion of arrangements for the risk share within the new Scheme.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with Executive Directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- Letters of Assurance from each Director;
- Reports from other inspection bodies;
- The work of the internal auditors, who submit to the Audit & Risk Committee regular reports, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- Comments by the external auditors in their management letters and other reports;
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees;
- The range of topics covered at Board Development Sessions, to develop the knowledge and awareness of both Executive and Non-Executive Board members;
- The Board's agreed approach to Risk Management established within the Governance Committees;
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, and the Clinical Governance Committee (which also embraces Information Governance & Security);

Data Quality

The Board receives a range of reports which include financial, clinical, and staffing information. In general, these reports are considered by the Executive Directors Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration and scrutiny of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (through the Information Governance & Security Steering Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies.

Risk Management

The Chief Executive of the NHS Board as Accountable Officer, whilst personally answerable to Parliament, is ultimately also accountable to the Board for the effective management of risk.

NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for an effective risk management strategy are set out in the SPFM.

All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix, the Risk Management Information System. Training and support for all Datix modules, including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities, and teams.

During 2020/21, the high level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high level risks, were reported as part of the Board Assurance Framework (BAF), to the governance committees on a bi-monthly basis, and thereafter to the Audit & Risk Committee and the Board.

Work is ongoing to review the Board's risk management arrangements, to ensure they continue to reflect good practice.

The Board agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by November 2020. This activity was delayed due to competing priorities arising from the pandemic. Further work is required to update and agree a risk appetite statement that states the type and level of risks to be eliminated, tolerated, or managed based on an assessment of the balance of risk versus reward. The review will take place in Q3 of 2020/21. This will involve consideration of the risk appetite of the Board in relation to both operational delivery and performance and strategy.

Performance against Risk Management Key Performance Indicators (KPIs) were reported to the Audit & Risk Committee during 2020/21.The adverse event components of the KPIs are reported to the NHS Fife Adverse Events & Duty of Candour Group, which reports through the Board's Clinical Governance structures. Further consideration will be given to KPI reporting to the NHS Fife Clinical Governance Committee.

The areas for development identified above will all be captured in the updated Risk Management Framework.

During 2020/21, the Director of Nursing, as Executive Lead for Risk Management, reported on all of the above to the Audit & Risk Committee.

Strategy Development and Strategic Planning and Resource Allocation

During 2020/21 the Board introduced a new Strategic Planning and Resource Allocation (SPRA) process. This is an annual process that details how each directorate/programme supports the delivery of the overall organisational strategy. The new process informed the development of the Operational Plan (RMP3) for 2021/22. Through this process, Directorate positions were consolidated, and investments and disinvestments prioritised to deliver the most effective allocation of resources. The prioritisation was influenced by the Scottish Government policy objectives and the recurring impact of Covid-19. The prioritisation process also reflected that the NHS in Scotland will operate under the direction of the Scottish Government at least until the end of June 2021.

The SPRA process creates a planning and resource allocation framework to support the development of the organisational strategy for NHS Fife. This will inform the medium-term financial plan and long-term strategic plan for NHS Fife.

Information Governance and Security

The Internal Audit Annual Report 2019/20 highlighted that assurance on the effectiveness of the Board Information Governance arrangements could be improved in some areas. During 2020/21 there was a key focus on delivering improvements to this important area of governance. As a result of the work undertaken, there has been an improvement in the effectiveness of our governance arrangements including enhancing the necessary processes and controls to provide a baseline of consistent and reliable assurance. Additionally, reporting on compliance with the control's framework has been developed and will be embedded in practice during 2021/22. There were no material deteriorations in levels of compliance against controls during 2020/21; indeed, several areas noted improved performance, including a reduction in the number of potential personal data related incidents or data protection breaches reported to the Information Commissioner (ICO), as detailed on p.17. A number of areas require further work to ensure consistent improvement and a plan has been established to target improvements in compliance where that is required, this will be continuously monitored during 2021/22.

Covid-19 Pandemic – Governance Arrangements

The business of the Board during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs on 25 March 2020 (the NHS in Scotland has remained on an Emergency Footing continually since that date). Individual NHS Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive; NHS Fife returned their own submission on 30 March 2020. At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at

allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

Since the outbreak of the pandemic in mid-March 2020, the Board has continued to hold its bi-monthly meetings remotely, utilising videoconferencing via MS Teams, with a prioritised agenda in place for each Board meeting. Whilst it has not been possible to meet physically in a public setting due to the ongoing lockdown restrictions and social distancing measures, from the May 2020 Board meeting onwards, representatives from the local media were invited to listen in via Teams. Arrangements for members of the public to join virtual meetings have also been in place since shortly after that date, with NHS Fife one of the first Boards to establish a process for remote public access. Board papers continue to be published in advance on the NHS Fife website, as do the Board minutes after each meeting has taken place.

Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. As per the letter from Richard McCallum, Director of Health Finance and Governance of 11 June 2020, prior notification of the intention to resume Committee meetings, and the rationale for that, was given by the Board to Scottish Government. Committee meetings largely resumed on their regular schedule from July 2020 onwards. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan was however reviewed to ensure that new items related to Covid-19 were covered appropriately and that the required assurances could be provided to the Board as part of the year-end process. Each Committee also actively considered a governance checklist, prepared initially by Internal Audit and recommended by the Audit & Risk Committee for adoption by all standing committees, to help enhance agenda planning and ensure that no areas of risk were overlooked.

During the height of the pandemic, in both the first and second waves of Covid-19 related activity, weekly meetings of the Chair, Vice-Chair and members of the Executive Team were held, with a detailed note circulated to Board members for their information. The Chair and Vice-Chair additionally had regular contact with the Chief Executive and other key members of the Executive Team on priority items as and when required. Regular meetings with local elected representatives (MPs/MSPs) also continued to operate on a monthly basis.

During both the first and second waves of the pandemic, NHS Fife established an organisational command structure to provide direction, decision-making, escalation, and communication functions during the busiest times of activity. Initially, from late March 2020, meetings of Gold Command were scheduled daily. By the end of June this was reduced this to weekly as a result of the reduction in Covid-19 related activity and reporting from its supporting Silver and Bronze groups. Routine meetings such as the weekly meeting of the Executive Team, and a formal Executive Directors' Group (EDG) meeting, were resumed in June. Gold Command - and its supporting structures below - stood up once again on a weekly basis, from September 2020 to the end of March 2021, to manage the second wave of the Covid-19 pandemic. The organisational structure utilised successfully in the first two phases of the pandemic will be re-introduced, should future circumstances require.

Disclosures

During the 2020/21 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting Date:	**Thursday 17 June 2021**
Title:	**Whistleblowing Standards Implementation**
Responsible Executive:	**Linda Douglas, Director of Workforce**
Report Author:	**Sandra Raynor, Senior HR Manager**

1. Purpose

This is presented to Audit Committee for:

- Awareness

This report relates to a:

- Government policy / directive
- Legal Requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2. Report Summary

2.1 Situation

From 1 April 2021 all NHS organisations are required to follow the National Whistleblowing Principles and Standards. The application of these statutory requirements is overseen by the new Independent National Whistleblowing Officer (INWO), the first of its kind in the UK, is a role undertaken by the Scottish Public Services Ombudsman. The Standards provide a mechanism for external review by the INWO of how a Health Board, primary care or independent provider handles a whistleblowing case.

The Standards require all organisations within the NHS to provide:

- A supportive environment for raising concerns.
- Access to a clear, timely two-stage procedure for raising concerns.
- Signposting to the INWO for independent review as the final stage in the process.
- Systems in place for recording, reporting, and learning from concerns.

NHS Fife along with all other Health Boards, primary care or independent providers are required to adopt these standards and work was completed to prepare for implementation in April 2021.

2.2 Background

The Standards were in development for a number of years prior to their adoption and together with the appointment of the INWO and the appointment of Non-Executive Whistleblowing Champions set out the expectations on all NHS service providers to promote of a culture of openness and transparency for handling concerns that are raised with them which meet the definition of a 'whistleblowing concern'.

Anyone raising concerns about the NHS in Fife are covered by the new National Whistleblowing Standards. After a concern has been through the local whistleblowing process whistleblowers have the option of raising a concern with the INWO if they are unhappy with the outcome.

To assist with implementation of the Standards, and to ensure those wanting to raise concerns have access to all the information they need in relation to the Standards, the INWO now provides an advice line for all NHS providers, staff and members of the public and this can be found on the INWO website.

2.3 Assessment

The Whistleblowing Standards are available to view on the website and were formally published on 1st April 2021, on the same date as the INWO went live. The Standards form the basis of the 'Once for Scotland' Whistleblowing Policy, which was also launched on 1st April 2021, along with additional guidance for NHS Boards. During the preparatory period the Workforce Directorate within NHS Fife, working with Staff Side colleagues, incorporated the Standards into policy, training, and procedural arrangements for both directly employed staff and independent contractors. This has allowed a period for both staff and managers to take up training and raise their awareness of the Standards.

In the reporting year 1 April 2020 to 31 March 2021, NHS Fife had no whistleblowing complaints / claims. Under the governance requirements within the Standards, NHS Fife must provide quarterly and annual reports on Whistleblowing activity to support learning from the handling of concerns. The first quarterly report on the Standards will cover the reporting period from 1st April to 30th June and will be submitted to the NHS Fife Board at its 27 July 2021 meeting.

Training for staff and managers is vital to ensuring the success of the Standards. Two learning programmes are available to help the transition to the new Standards. One for staff who need an overview of the Standards, which takes around an hour to complete; and the other for managers who need to handle and respond to whistleblowing, which takes two to three hours to complete.

The Standards require NHS Fife to have an appropriate recording system in place for recording and reporting of Whistleblowing concerns. Datix has been developed nationally as the system to meet the recording requirements set out in the Standards and is a familiar system to staff and managers. NHS Fife has adopted Datix as our recording system for Whistleblowing Concerns

NHS Fife's Non-Executive Whistleblowing Champion role was vacant on the 1st April 2021. An appointment was completed by the Scottish Government Public Appointments team and Kirstie MacDonald was formally announced as the new Non-Executive Whistleblowing Champion on 8 June 2021. The Whistleblowing Champion will seek and provide assurance that the Health Board is complying with the Whistleblowing Standards.

All primary care providers and contracted services are required to have a procedure that meets with the requirements of these Standards. This means that any organisation delivering NHS services, whether it is a private company, a third sector organisation or a primary care provider, has the same requirement to ensure access to a procedure in line with these Standards. This includes third sector organisations providing services on behalf of NHS Fife and private companies under contract with NHS Scotland, including maintenance and domiciliary services. Work during the period prior to launch of the standards has established initial arrangements, and these continue to be refined through our implementation group to ensure effective compliance and governance reporting.

As well as our local preparation work, national HR and key stakeholder engagement activity, including liaison with the INWO have been supporting work to adopt the Standards. This sharing of practice will continue during this first year to ensure we manage the implementation effectively, recognising the continuing need to grow practice in the Independent Contractor sector.

In summary the Committee can be assured that we have managed the initial adoption of the standards through:

- Promotion of the new arrangements to staff, with appropriate reference to new INWO role, and the Whistleblowing Standards and process for raising concerns.
- The launch of the national manager and staff training resources to support the application of the Standards.
- Work in partnership to develop our response to the Standards with development and distribution of guidance resources, and additional support through the confidential contact network.
- Engagement with primary care and independent contractor representatives to ensure that the communication of requirements, contact points and reporting provisions are in place.
- Continuation of work to refine the arrangements through the local implementation group, which will consider learning from local practice and from other Board experience.
- Provision in place for the governance and reporting of Whistleblowing activity.

It is anticipated that a report will be presented to the Audit & Risk Committee following a review our experience during the first year of implementing the Standards. It is projected that this report will be presented to the Audit Committee in the middle of 2022.

2.3.1 Quality / Patient Care

Ensuring effective governance oversight is applied across the organisation in terms of any issue of whistleblowing is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

The monitoring of whistleblowing across the organisation ensures colleagues are afforded the highest standards of governance as set out in the NHS Scotland Staff Governance Handbook and a culture which supports the appropriate raising and handling of concerns.

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

Dealing appropriately with whistleblowing claims is an important factor in the identification and management of risk and providing appropriate assurance to the Fife NHS Board.

2.3.5 Equality and Diversity, including Health Inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people.

2.3.6 Other Impact

N/A

2.3.7 Communication, Involvement, Engagement and Consultation

Over the course of 2020 regular updates on the introduction of the INWO and the Whistleblowing Standards have been presented to various committees. They have been considered at LPFs, APFs, Staff Governance Committee and NHS Fife Board,

2.3.8 Route to the Meeting

The Whistleblowing Standards have previously been considered through standard governance routes.

2.4 Recommendation

The Audit Committee is asked to **note** the update on the implementation of the Whistleblowing Standards.

Report Contact:

Sandra Raynor
Senior HR Manager
E-mail: sandra.raynor@nhs.scot

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Audit and Risk Committee with comprehensive assurance on the progress of the 2021/22 Internal Audit Plan and the ongoing delivery of the 2020/21 Internal Audit Plan.

The short period of time between the May 2021 and June 2021 Audit and Risk Committee meetings means that there no significant changes from the last report.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team continues to deliver the remaining reviews from the 2020/21 plan under the supervision of the Chief Internal Auditor. We have experienced some delays in progressing audits but all work will be completed to allow consideration as part of the Annual Report for 2020/21. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

A large element of our year-end assurance work has been delivered through the Internal Control Evaluation and Sustainability audit; final assurance will be derived from the 2020/21 Annual Internal Audit Report.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls and forms part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

2.3 Assessment

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the Audit Follow-up System, which is maintained and reported to the Audit and Risk Committee by Internal Audit.

Due to IT difficulties, we are unable to provide KPIs around the time budget.

Appendix A shows:

- Final Internal Audit Reports Issued Since the last Audit and Risk Committee
- Internal Audit Reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- Summary of Internal Audit Findings in Final Internal Audit Reports issued since the last Audit and Risk Committee
- Internal Audit Performance against Service Specification Key Performance Indicators.

Advice and input

In addition to formal audit reviews which result in a report to the Audit and Risk Committee, Internal Audit have continued to provide advice and assistance to officers and Board members on the following areas since the last Audit and Risk Committee meeting, including:

- Assurance mapping and risk advice, in particular Digital and Information risks
- Advice on the Annual Reports for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.

Improvement Activities

Further work since the May 2021 Audit and Risk Committee meeting includes:

- Development of the FTF website which is ongoing.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** and **NOTE** the progress on the delivery of the Internal Audit Plans.

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Report Contact:
Barry Hudson
Regional Audit Manager
Email: barry.hudson@nhs.scot

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 7 June 2021.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 13 May 2021. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2020/21	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B09/21 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee and year end summary to May 2021 Audit and Risk Committee
B26/21 – Financial Process Compliance	N/A	1 Merits Attention	23 April 2021	18 May 2021

NHS Fife Draft Reports Issued

Audit 2020/21	Draft issued
B13/21 – Risk Management	7 June 2021
B22/21 - Workforce - Review of Manual Handling Arrangements	12 May 2021
B23/21 - Information Technology Infrastructure Library (ITIL) Processes	28 May 2021

B28/21 - Digital and Information Governance Arrangements	24 May 2021

NHS Fife Work in Progress and Planned:

Audit 2020/21		Status	Target Audit and Risk Committee
B19/21	Clinical Governance Strategy and Assurance including Scottish Patient Safety Programme	Fieldwork	Both these reviews had a target Audit and Risk Committee of 13 May 2021 but delays were experienced due to the following factors: • Client staff availability due to COVID commitments. • Staff from the FTF Fife team assisting in other FTF clients due to long term sickness (Covid) and staff vacancies in other FTF Client Boards. We have completed the fieldwork for these reviews, with the aim to issue these as draft reports prior to the June Audit and Risk Committee.
B21/21	Medical Equipment and Devices	Fieldwork	
B15/21	Resilience	Planning	9 December 2021

Audit 2021/22		Status	Target Audit and Risk Committee
B06/22	Internal Audit Annual Report	Fieldwork	15 September 2021
B16/22	Medicines Management	Planning	9 December 2021
B19/22	Post Transaction Monitoring	Planning	15 September 2021

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of May 2021 where a progress report was considered.

1. B09/21 Audit Follow Up (AFU)

Full report included on the agenda for the June 2021 Audit and Risk Committee.

Throughout 2020/21, Internal Audit have provided a comprehensive Audit Follow Up (AFU) report to each Audit and Risk Committee and updated the AFU protocol. Enhancements to the reporting have been made during the year and the Executive Directors Group has monitored the action taken in year for the outstanding recommendations. The EDG now consider the progress on internal audit actions quarterly with Directors being reminded of the need to ensure good progress is made in clearing outstanding issues. We can confirm that we had an encouraging response from several Directors following the last quarterly update to the EDG resulting in a welcome push to move outstanding recommendations to completion.

2. B26/21 – Financial Process Compliance Accounts Receivable and Travel Expenses

This review provided assurance that for the noted key financial systems, processes and procedures are established and meet the requirements of the Financial Operating Procedures (FOPs) and the relevant Standing Financial Instructions. This exercise tested outputs from; and certain procedures within Accounts Receivable and Travel Expenses financial systems. Due to the limited nature of the review undertaken, we did not provide a full audit opinion on each system. However, based on the testing carried out, we found no evidence to suggest that either system is failing to meet business objectives.

The high level review and sample testing of the Travel Expenses system concluded that appropriate guidance is available for expense payment and authorisers and compilers, an appropriate system is in place to only appoint authorisers to the staff that they are responsible for, authorisation of eExpense claims were made by an appropriate officer and journeys on eExpense claims were correctly recorded.

From our high level review and sample testing of the Accounts Receivable system we concluded that debtors invoices were raised timeously and accurately, cheque and BACS payments to NHS Fife were accurately recorded and posted within appropriate timescales, credit notes and cancellations examined were found to be appropriately authorised. We confirmed that monthly reconciliation of outstanding debtors to the ledger is undertaken by ledger staff and checked by management, the register of accounts to be written off is prepared annually and is authorised by the Head of Financial Services and aged debtors are reviewed on a monthly basis and reminder letters sent in accordance with the FOPs to recover debt.

The *Audit Scotland Covid-19 Guide for Audit and Risk Committees* was used as a basis to design a questionnaire for this review to provide additional assurance around post-Covid controls. Through discussion with lead officers and the completion of the questionnaire, we noted that careful consideration was given to ensure the control environment was not impacted by the move to home working with the Director of Strategy & Finance confirming that there

was no requirement to revise internal controls within the financial processes as a result of Covid-19.

Key Performance Indicators
2020/21

Performance against service specification as at 17 June 2021:

	Planning	Target	13 May 2021	17 June 2021
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	73%	73%
2	Draft reports issued by target date	75%	56%	53%
3	Responses received from client within timescale defined in reporting protocol	75%	80%	83%
4	Final reports presented to target Audit Committee	75%	73%	47%
5	Number of days delivered against plan	100% at year-end	System Issue – not provided	System Issue – not provided

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Audit follow up position at 1 June 2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

Good practice guidance, as laid out in the Audit Committee Handbook, emphasises the importance of effective follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented.

2.2 Background

The EDG now consider the progress on internal audit actions quarterly with Directors being reminded of the need to ensure good progress is made in clearing outstanding issues. We can confirm that we had an encouraging response from several Directors following the last quarterly update to the EDG resulting in a welcome push to move outstanding recommendations to completion.

External Audit recommendations will continue to be followed up through NHS Fife Finance Directorate and Internal Audit will continue to review progress against External Audit recommendations where relevant to internal audit fieldwork.

Internal Audit will validate the evidence supplied by responding officers for actions they are declaring as completed to confirm that those actions address the recommendations made.

2.3 Assessment

In order to focus on addressing actions which are not yet complete, we only including reports which have actions with a status of Extended, Outstanding or Not Yet Due. All

reports that had completed actions or had been superseded by subsequent reports have been removed from the tables and figures below. .

Recommendation 8 from B32/20 – NHS Scotland waiting Times Methodology had previously been reported by the Responsible Officer as complete but our validation process identified that the methodology had not been added to the Patient Access Policy as agreed. This is to be addressed in the next iteration of the policy which is currently being reviewed. The action is therefore recorded as extended to 31 July 2021 and will be recorded as completed upon submission of the revised policy to the General Policies Group.

The table below shows the status of all remaining internal audit recommendations as at 1 June 2021, with comparable figures from the last Audit Follow-Up (AFU) report in May 2021.

	May 2021	**June 2021**
Remaining Recommendations	**53**	**49**
Extended with revised dates (agreed by Responding Officer)	40	33
Outstanding – Date passed	2	6
Not yet due	11	10

A one-off exercise, out with the scope of the Audit Follow-Up Protocol, was undertaken prior to the May Audit & Risk Committee to improve progression of actions and provide assurance that the risks and consequences of non-completion had been appropriately considered and priorities directed accordingly.

The removal of the identified recommendations from the follow-up process was approved, allowing focus on the remaining 49 recommendations which are either not yet due, have had their target implementation dates extended (*Appendix C*) or have lapsed target implementation dates with no communication of status having been provided by management (*Appendix D*).

Appendix D also highlights those actions where responding officers have reported delays in progressing actions due to prioritisation of COVID-19 duties.

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

We have assessed progress to date for responses in relation to those remaining recommendations with extended target implementation dates and a RAG status is included to aid prioritisation.

Audit Follow Up Protocol

The Audit Follow-Up Protocol was revised to reflect a change in focus to address outstanding recommendations and improve Client response times and was approved at the May 2021 Audit and Risk Committee meeting.

2.3.1 Quality/ Patient Care

There are no direct implications for Quality/Patient Care as a result of this report.

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 Risk Assessment/Management

The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor and the Director of Finance and Strategy ahead of submission to the Audit and Risk Committee.

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

- **note** and consider the current status of Internal Audit recommendations recorded within the AFU system.

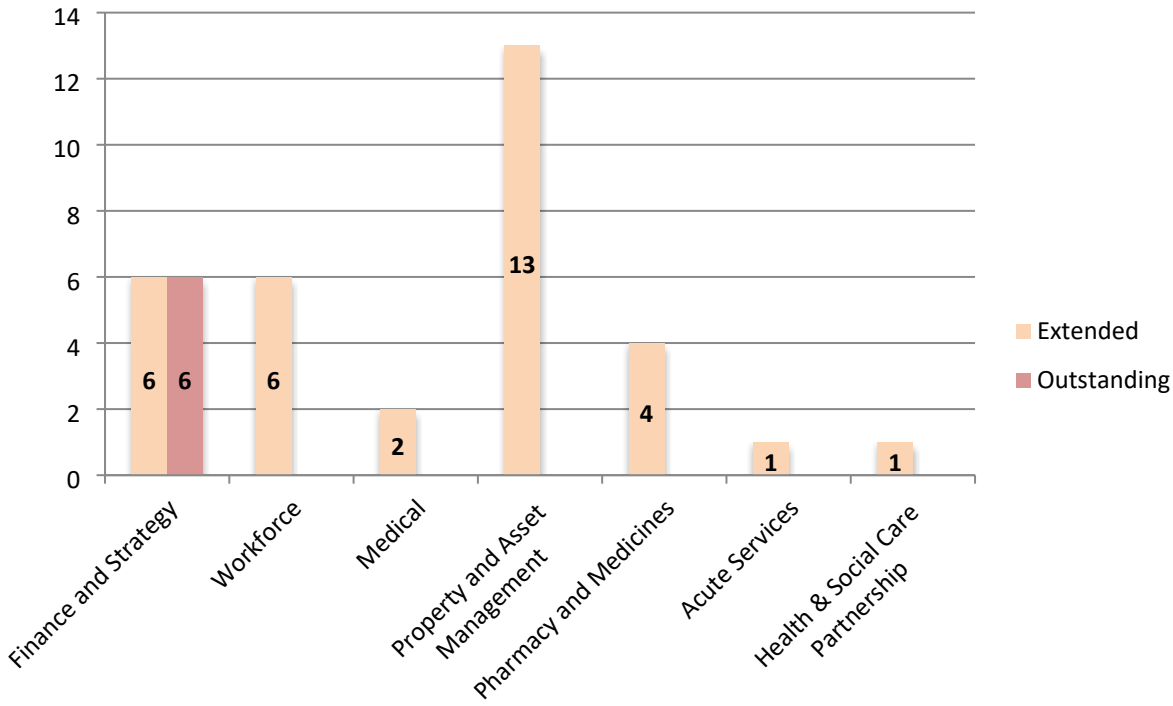
3. List of appendices

The following appendices are included with this report:

Report Contact

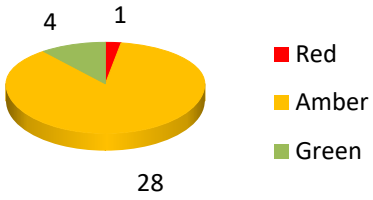
Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

Outstanding and Extended by Directorate

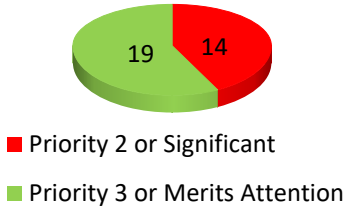


Extended Recommendations RAG Status and Priority

RAG Status

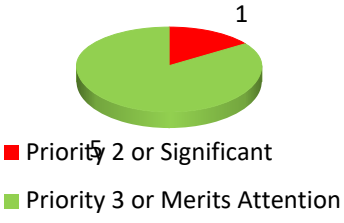


Priority



Outstanding Recommendations (No response) Priority

Priority



	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2018/19											
B11/19 Mandatory Training	Aug-19	3	0	0	3		3	0	0		-
B22/19 Losses & Comps	Apr-19	8	3	0	5		0	5	0		-
B23&24/19 Savings & Financial Planning	Sep-19	2	1	0	1		0	1	0		-
B25/19 Financial Management	Mar-20	2	0	0	2		2	0	0		-
2018/19 Totals		**15**	**4**	**0**	**11**		**5**	**6**	**0**		**0**
2019/20											
B08/20 Internal Control Evaluation	Jan-20	15	8	6	1		1	0	0		1
B13/20 Risk Management Staging	Jun-20	3	0	0	3		3	0	0		-
B14/20 Staff & Patient Environment	Dec-19	3	0	0	3		3	0	0		-
B17/20 Organisational Performance Management	Oct-20	6	1	0	5		0	0	5		-
B19/20 Adverse Events Management	Mar-20	4	2	0	2		2	0	0		-
B21/20 Medicines Management	Dec-19	23	19	0	4		4	0	0		2
B23A/20 Workforce Planning	Jan -20	4	2	0	2		2	0	0		-
B27/20 Financial Process Compliance	Jan-20	2	1	0	1		1	0	0		-
B32/20 Waiting Times Methodology	Mar-20	13	12	0	1		1	0	0		1
2019/20 Totals		**73**	**41**	**6**	**22**		**17**	**0**	**5**		**4**
2020/21											
B14/21 Sharps Management	Dec-21	14	0	0	14		11	0	3		-
B25/21 Property Transaction Monitoring	Sep-20	4	2	0	2		0	0	2		-
2020/21 Totals		**18**	**2**	**0**	**16**		**11**	**0**	**5**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**106**	**47**	**6**	**49**		**33**	**6**	**10**		**4**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2018/19							
B11/19 Mandatory Training	1	3	A central record of course updates and reviews should be maintained and provided to the SGC at least annually.	Head of Workforce Development **Director of Workforce**	31-Mar-20 30 Apr 21 31 Aug 21		The Director of Workforce will undertake a project to address this.
	2	3	A policy on mandatory training requirements to be followed by staff should be introduced.	Director of Workforce **Chief Executive**	31-Mar-20 30 Apr 21 31 Aug 21		The needs are different across the organisation so writing a policy on mandatory training requirements would be challenging e.g. not all core topics including in mandatory skills is applicable to all roles
	3	3	The SGC should receive assurance regarding NHS Fife addressing its mandatory training obligations.	Head of Workforce Development **Director of Workforce**	31-Mar-20 30 Apr 21 31 Aug 21		NHS Fife are working on a more sustainable format for producing these reports more regularly in future that does not have such a big impact on time/ resources until the reporting function is available.
B25/19 Financial Management	1	S	Section 5 of the FOP Appendix A should be updated to include appropriate designations and authorisation levels and the reporting method for virements which are not fully delegated.	Deputy Director of Finance **Director of Finance and Strategy**	31-Jul-20 30-Apr-21 31-Oct-21		Due to capacity issues within the Finance Directorate and the requirement for the Financial Management Team to lead on the Annual Accounts process the responses to the audit recommendations remain a work in progress.
	2	M A	Virement approval should be In line with Section 5 of the FOP 9.2 and 9.3, which requires use of the Vacancy Management Form. Due consideration should be given to any extant control processes in place with immediate effect to realign these budgets.	Deputy Director of Finance **Director of Finance and Strategy**	31-Mar-20 30-Apr-21 31-Oct-21		Due to capacity issues within the Finance Directorate and the requirement for the Financial Management Team to lead on the Annual Accounts process the responses to the audit recommendations remain a work in progress.
18/19 Sub Total	**5**						
2019/20							

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B08/20 Internal Control Evaluation	1	S	Work has commenced to review the integration scheme which is line with the actions outlined in the MSG report.	Director of Health & Social Care **Chief Executive**	31-Apr-20 30 Apr 21 30 Sep 21		As of 23 December 2020, with the exception of the finance section, the revised integration scheme for Fife is now approaching a version that is fit for circulation, Internal Audit have been asked to comment on the updated document by 13 January 2021 so that a revised version can go through the January committees. *[Internal Audit comment - In Progress, a draft revised integration scheme has been developed albeit financial risk share is unresolved]*
B13/20 Risk Management Staging	1	S	Risk Management Framework is mostly still in progress and we recommend that a project plan is developed and produced with any remaining actions required, realistic key dates and milestones to enable the monitoring of the plan and ensure a timely completion.	Risk Manager **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.
	2	S	There is further scope to enhance the strategic aspects of Risk Management within NHS Fife, within the context of the risk appetite consulted and agreed by the Board and the implementation of DL(2019) 02 Blueprint for Good Governance.	Risk Manager **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.
	3	S	The IJB risk management arrangements should be clarified between the Fife Integration Joint Board and NHS Fife with particular reference to the treatment of residual risk and escalation process with the Fife IJB, the Health and Social Care Partnership and Fife NHS Board. The governance arrangements regarding risk management with the Fife IJB, and the Fife Health Care Partnership should be recorded in the Risk Register and Risk Assessment policy GP/R7.	Risk Manager **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B14/20 Staff & Patient Environment	1a	M A	When available the 'Non-Compliance' report from the eESS system should be used to identify areas/departments/wards with low levels of attendance at Fire Safety Training so that these areas/departments/wards can be supported to improve attendance.	Learning & Development Officer **Director of Workforce**	31-Mar-20 31-May-21 31-Jul-21		Work has not progressed with the eESS National team despite numerous attempts over the last few months. A report has been developed to identify compliance however, despite requesting a non-compliance report the team have yet to develop this.
	1b	M A	The report should be developed to confirm that all staff who require more specialist training (eg Responsible Persons, Fire Wardens) receive this type of training.	Estates Compliance Manager **Director of Property and Asset Management**	On-going 31-May-21 31-Jul-21		On a more local level within NHS Fife, work will begin in 2021 to roll out the Learner functions within eESS which will give an employee and their manager access to individual learning histories in order to support local awareness of compliance. In addition to this, a Core Skills report will be issued to every manager over the next few months detailing compliance for each member of their team – this will further raise non-compliance awareness on a local level.
	2	M A	Further Standard Operating Procedures should be developed for components of the operational system for fire safety in NHS Fife and the sections for these processes should be summarised in the NHS Fife Fire Safety Procedure and cross references to the appropriate SOPs added.	Estates Compliance Manager **Director of Property and Asset Management**	31-Mar-20 31-May-21 31-Jul-21		A memo has been developed on interim training arrangements, whilst it is not a full SOP it is still an introduction which pulls together the requirements from our Policies & Procedures. This will be used as a baseline to develop into a full SOP as time progresses. This has been shared with a group of 60 staff/managers and has been uploaded to Stafflink.
B19/20 Adverse Events Management	2	S	A review of actions still open for 2018 and 2019 revealed there to be 70 SAER actions and 95 LAER actions still open and overdue completion. An action plan should be drawn up to enable steps to be taken to finalise the backlog of actions currently outstanding and ensure greater effort is made to have actions completed by the respective due date.	Head of Quality & Clinical Governance **Medical Director**	31-Jul-20 30 Apr 21 31-Jul-21		December update: Discussions about establishing processes for reporting of action status through local governance routes has begun. This is now included in the reports which are presented by Directorates to the ASD CGC. The HSCP are improving reporting which is to be extended to include the reporting of outstanding actions. Reports with data and information relating to actions are now part of KPIs which are now reviewed and monitored through the Adverse Events and Duty of Candour Group. This is a standard agenda item. Reports are now created in Datix and are accessible by Directorates.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3	S	Sufficient explanation is not being provided within DATIX on the steps taken to implement the actions for SAERs and LAERs. Staff should be reminded to fully note on DATIX what steps have been taken to implement actions; including what shared learning has actually taken place. Additionally, a review of the fields on DATIX for recording details of the steps taken to implement actions should be completed, so that staff can be more readily directed to note the final outcome.	Head of Quality & Clinical Governance **Medical Director**	30-Jun-20 30 Apr 21 31-Jul-21		December update: The Adverse Events and Duty of Candour Group did not meet from March until August due to Covid-19 pandemic. The regular meeting schedule resumed in August 2020. This will be an item on the agenda to be discussed at the December 2020 meeting.
B21/20 Medicines Management	4 a-c	S	Training of Pharmacy, Transport and clinical staff to be reviewed.	Senior Pharmacy Technician **Director of Pharmacy & Medicines**	31-Mar-20 31-May-21 31-Jul-21		Responsible officer is currently a Covid Vaccinator
	8	M A	Medicines Uplift and Delivery Form must be redesigned and this must include consideration of the issues identified by Internal Audit. Ultimately an electronic alternative solution must be explored.	Lead Pharmacy Technician **Director of Pharmacy & Medicines**	31-Mar-20 30 Apr 21 31-Jul-21		Work is ongoing.
B23a/20 Workforce Planning - Attendance Management	2	M A	A communication to be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.	Head of HR **Director of Workforce**	31-Dec-19 31-May-21 31-Aug-21		Covid-19 responsibilities – this will tie in with services moving out of an emergency footing and back to normal.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	4	M A	A review should be undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.	Director of Workforce **Chief Executive**	31-Mar-20 31-May-21 31-Aug-21		Covid-19 responsibilities – this will tie in with services moving out of an emergency footing and back to normal
B27/20 Financial Process Compliance	2	M A	Financial Operating Procedures to be updated.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-20 30 Apr 21 31 -Jul-21		The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
B32/20 NHS Scotland Waiting Times Methodology	7	M A	Appendix 1 of Patient Access Policy should be updated to specifically refer to the NHS Scotland Waiting Times Monthly Audit Methodology and to include this as a further appendix.	Head of Information Management **Director of Acute Services**	30-Apr-20 31-Jul-21		Partially implemented The methodology is referred to in the Patient Access Policy appendix 1 but is not included as an appendix.
19/20 Sub Total	**17**						
2020/21							
B14/21 Sharps Management	1a 1b 1c	M A	Corporate risk to be discussed and recorded regarding non-compliance with the Health & Safety (Sharp Instruments in Healthcare) Regulations 2013. Corporate risks to be recorded regarding all HSE reports/improvement notices that require rollout across the organisation.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a 29-Jan-21 b 12 Feb 21 c 31 Dec 20 30-Jun-21		Work is ongoing

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	2a 2b 2c 2g	M A	Sharps Management and Use Policy and procedures to be updated to address issues raised in report and to update 'intranet' to 'stafflink' and to update email addresses to '...nhs.scot'. Pharmacy management to be contacted to ensure patients being discharged with injectable medicines are also prescribed with a sharps bin.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a 31 Dec 20 b 22 Jan 21 c 12 Feb 21 g 29 Jan 21 30-Jun-21		Work is ongoing
	3a 3b 3c 3d	S	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee. The Health and Safety Sub-Committee to be reminded of their responsibility to escalate issues to the Clinical Governance Committee when required.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a. 3-Feb-21 b. 3-Feb-21 c. 10-Feb-21 d. 30-Dec-20 30-Jun-21		Work is ongoing
20/21 Sub Total	**11**						
Total	**33**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Original Management Response	Priority	Original Due Date
2019/20							
B22/19 Losses & Comps		1a, 3 & 6	Managers responsible for recording incidents should be reminded of the requirement to follow FOP16a for all cases where property is lost, damaged or written off.	Head of Financial Services & Procurement **Director of Finance and Strategy**	Response from January 2021 - The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.	3	31-Jul-19
		2b & 5	The losses and compensation form included in FOP16a should be amended to include: • provision for a cross reference to the related Datix incident • a section regarding the prevention of recurrence of losses.	Ledger Control and Treasury Manager **Director of Finance and Strategy**	Response from January 2021 - FOP Update on going	3	31-Jul-19
B23&24/19 Savings & Financial Planning		2	The process for reviewing efficiency saving opportunities should include consideration of the interdependencies in, and between, the Health Board and the IJB both in respect of additional savings opportunities to mitigate risks of adverse consequences up or down stream from where an efficiency project is being implemented	Director of Finance and Strategy **Chief Executive**	Previous AFU response - Work on this has commenced, however has been delayed due to the mobilisation of the local response to COVID 19.	2	21-Mar-20
19/20 Sub Total		**6**					
Total		**6**					

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
2019/20						
B08/20 Internal Control Evaluation	4	**Finding** Consideration of External reporting related to Clinical Governance areas had been removed from the CGC agenda but related changes to responsibilities in its terms of reference and items on its workplan had not been made. Reporting of External Report findings did not include triangulation with other data sources and did not specifically consider why internal control mechanisms had not identified the issues reported by external bodies. **Recommendation** The change in approach should be reflected in the relevant Terms of Reference and Workplans.. A year-end summary of NHS Fife responses to External and Internal reports should be included in the CGC Annual Statement of Assurance. Consideration should be given to triangulating significant findings from external inspections with the issues identified by internal control systems. In addition to responding to the substantive points within the external report(s), NHS Fife undertake a holistic review to understand why internal systems did not identify these issues.	S	**Medical Director** **31 Mar- 2020**	The follow-up response records the following: • The Activity Tracker has been removed from the CGC Workplan • The CGC ToR accurately reflects the process in place for external reporting including escalation to CGC where required • The CGC Annual Assurance report includes reference to relevant external reports • The C&CGC is considering external reports at each of its meetings and monitoring mechanisms are in place to identify these.	The action is partly complete as reference to external reports was included in the Annual Assurance Report of the Clinical Governance Committee. This however did not fully address the recommendation made as it did not include triangulation with other data sources and did not comment on or include any analysis regarding why existing control arrangements did not identify the issues picked up by external bodies in their reports. In order to be validated as complete evidence is therefore required of: • Analysis regarding why internal control mechanisms didn't flag up the issues identified in external reports and the conclusion of this being presented to the CGC • Triangulation between different quality/performance data sources being presented to the CGC.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
B21/20 Medicines Management	6a&b	**Finding** SECURITY/HEALTH AND SAFETY A number of issues were identified from Questionnaires: **Recommendation** The methods for communicating Health and Safety risks and the need for special storage conditions to taxi drivers when passing medicines over for collection, and to clinical staff when handing medicines over at their final destination, must be examined to confirm that they are effective and address the weaknesses identified above. The SSUMPP must be updated to include an explicit instruction that medicines must never be left unattended at their destination point and to provide guidance for staff delivering medicines on the steps to be taken if no-one is available to receive the medicines at the destination point.	Merits Attention	Lead Pharmacy Technician **Director of Pharmacy & Medicines** 31-Mar-2020	At SSUMPP group it was agreed that we had sufficient evidence that there was a risk and that the only way to eradicate the risk was direct delivery to wards. There was a transport run at 1630 every day with direct delivery to wards in April. From Monday 14th December a second run will be introduced again with direct delivery to wards.	Can only be considered complete if the SSUMPP has been updated to include an explicit instruction that medicines must never be left unattended at their destination point and to provide guidance for staff delivering medicines on the steps to be taken if no-one is available to receive the medicines at the destination point. No evidence of this has been provided.
B32/20 NHSScotland Waiting Times Methodology	5	**Finding** Finding 5 from Internal Audit Report B29/18 – NHS Scotland Waiting Times Methodology has not been addressed. This related to the impact of exceptions on the patient journey (in terms of extra time waiting) not being calculated and recorded.	Merits Attention	Secretarial Services & Waiting Times Team Manager **Director of Acute Services** 30-Apr-2020	The General Manager – Waiting Times advised on 25 May 2021 that provision for the calculation of extended patient waiting time for identified exceptions was included in the audit spreadsheet and agreed to send on evidence of this and the reporting of extended	This will be recorded as completed and validated once evidence of the calculation, and reporting, of extended patient waiting time for identified exceptions is provided.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		The NHS Scotland Waiting Times Monthly Audit Methodology requires that the impact on the patient journey should be calculated for any exceptions identified. **Recommendation** The impact on the patient journey in terms of extra time waiting should be calculated for exceptions identified and be recorded on the spreadsheet used to collate the results so that this can be included in reporting.			times.	
2019/20 Sub Total	**4**					
Total	**4**					

Action Status	
Term	**Definition**
Complete	Client has informed Internal Audit that the action has been implemented
Superseded	Action has been updated within a further audit report
Extended	Client has requested further time to implement the action (see A**ppendix D**)
Outstanding	The original, or extended, due date has passed and the client has not provided an update or requested an extension to the due date (see A**ppendix E**)
Not Yet Due	Original action by date has not yet occurred
Not Validated	Client has informed Internal Audit that the action has been implemented but our validation process found that further evidence is required to support this conclusion (see A**ppendix F**)

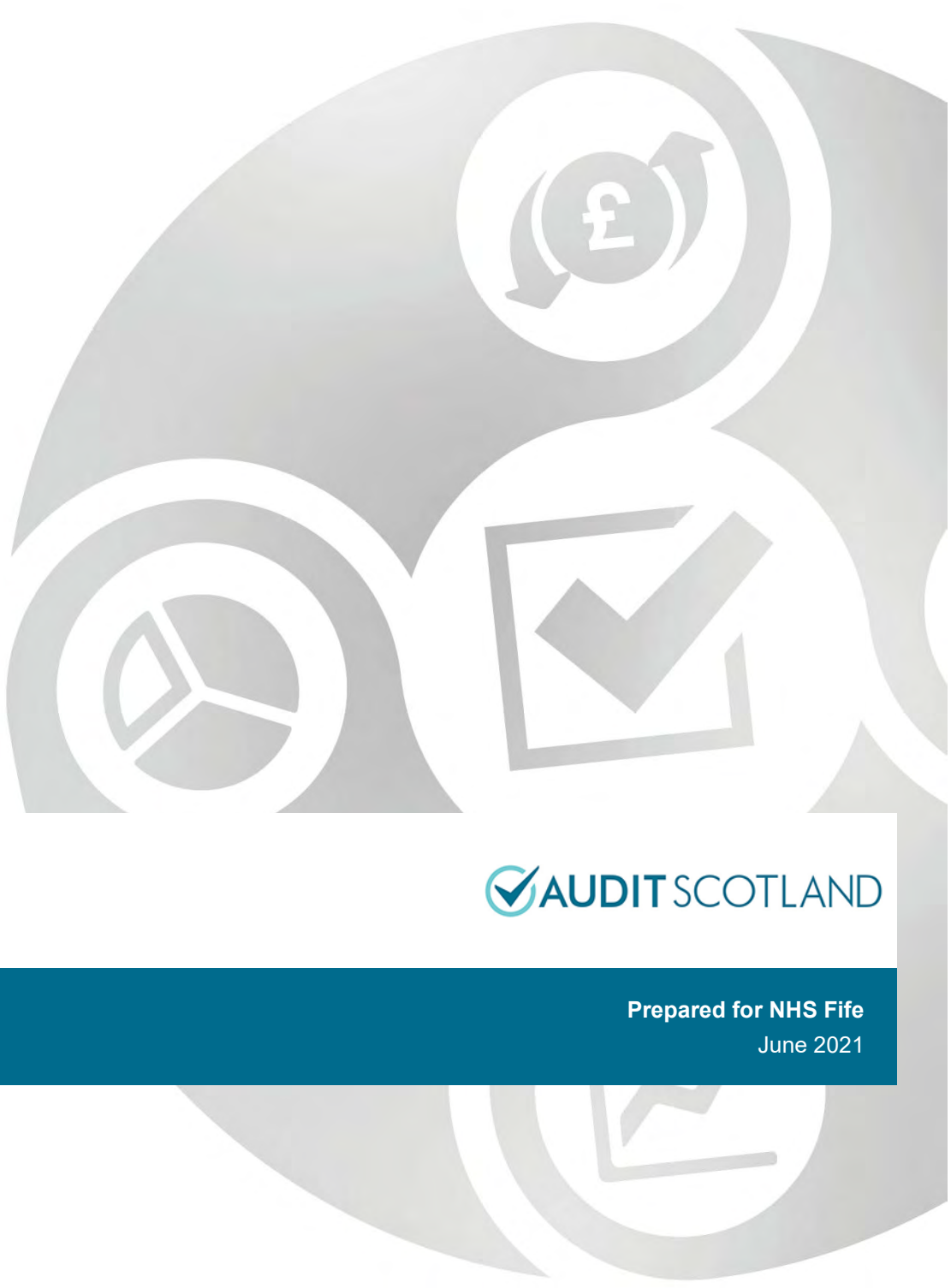
As our report format, including categorisation of audit opinion and report recommendations, changed in audit year 2018/19 the priority of the recommendations referred to in this report are quoted using two different systems. These are included in the table below:

Recommendation Priority	
Term	**Definition**
More Recent Reports	
Fundamental (F)	Non Compliance with key controls or evidence of material loss or error. Action is imperative to ensure that the objectives for the area under review are met.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.
Older Reports	
Priority 1	Relate to critical issues, which will feature in our evaluation of the Governance Statement. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.
Priority 2	Relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.
Priority 3	Are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.
Priority 4	Are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.

RAG Status Definitions for Importance of Extended and Outstanding Recommendations		
RAG Status		**Definition**
Red		**Action is imperative to ensure that the objectives for the area under review are met and risks are mitigated.**
Amber		**Stated actions have not been progressed sufficiently to mitigate the identified risk. Completion of updated actions should ensure objectives are achieved.**
Green		**Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks.**

NHS FIFE

Management report 2020/21



AUDIT SCOTLAND

Prepared for NHS Fife
June 2021

Audit findings

Introduction

1. This report contains a summary of the key issues identified during the interim audit work carried out at NHS Fife. This work included testing of key controls within financial systems to gain assurance over the processes and systems used in preparing the financial statements. We will use the results of this testing to determine our approach during the 2020/21 financial statements audit.

2. Our responsibilities under the *Code of Audit Practice* require us to assess the system of internal control put in place by management. We seek to gain assurance that the audited body:

- has systems of recording and processing transactions which provide a sound basis for the preparation of the financial statements
- has systems of internal control which provide an adequate means of preventing and detecting error, fraud or corruption
- complies with established policies, procedures, laws and regulations.

3. We have also under the *Code of Audit Practice,* carried out work on the wider dimension audit. This focussed on financial management, financial sustainability, governance and transparency and value for money.

Conclusion

4. Overall, we found the key controls in place within NHS Fife's main financial systems operate satisfactorily. We identified several control weaknesses as summarised in Exhibit 1 where we will be carrying out additional work in response to these findings.

5. In terms of our wider dimension audit work, this is ongoing with some areas for improvement as set out in Exhibit 1. This will inform our Annual Audit Report to be issued to NHS Fife in September 2021.

6. The contents of this report have been discussed with relevant officers to confirm factual accuracy. The co-operation and assistance we received during the course of our audit is gratefully acknowledged.

Work summary

Key financial controls

7. Our 2020/21 review covered key controls including bank reconciliations, payroll validation and exception reporting, authorisation of journals, change of supplier bank details, IT access controls, budget monitoring, control feeder system reconciliations and authorisation of expenditure.

Bank reconciliations

Payroll controls

IT access

Budgets

8. In accordance with *ISA 330: the auditor's response to assessed risk*, our audit judgements are based on current year testing of controls and where appropriate prior year results. Our risk-based audit approach allows us to take a three-year cyclical approach to controls testing. This approach enables us to place reliance on previous years' audit work where controls remain unchanged and no significant weaknesses had been identified. Also, where possible we place reliance on the work of internal audit to avoid duplication of effort.

Wider dimension work

9. We followed up the findings from our prior year work on financial planning and financial sustainability including reviewing the reliance on non-recurring savings.

Financial management

10. We have reported for a number of years that NHS Fife continues to rely on non-recurrent savings including internal financial flexibility of unspent allocations, to deliver against its financial targets.

11. NHS Fife's Annual Operational Plan reported a savings target of £20 million for 2020/21, including unmet savings of £12.6 million brought forward from previous years. This target increased to £21.8 million, with an additional £1.8 million savings target identified by the IJB after the start of the financial year.

12. Covid-19 had a significant impact on NHS Fife's ability to achieve the savings required and at the end of February 2020/21, NHS Fife had delivered £11.7 million (58%) of savings including £5.4 million of recurring savings and £5.7 million of non-recurring savings. These non-recurring savings will contribute to budget pressures in 2021/22.

13. In February 2021 the Scottish Government confirmed that all unachieved savings would be centrally funded for the current year. This enabled NHS Fife to close the £10.1 million gap for 2020/21. However, there has been no commitment from Scottish Government to fund unachieved savings in future years.

14. Although funding has been secured for 2020/21 there remains significant and unresolved financial risks in future financial years

Strategic planning and resource allocation process

15. During 2020/21 NHS Fife started developing a strategic planning and resource allocation (SPRA) process to support workforce, financial and organisational planning. All services were asked to submit information on their key objectives, key stakeholders, workforce and financial assumptions, digital, estates and facilities requirements and key risks.

16. In the short-term, the SPRA process has informed the development of the latest version of NHS Fife's Remobilisation Plan (RMP3). RMP3 is acting as the current strategy for 2021/22 and reflects the ongoing challenges caused by Covid-19.

17. In the medium-term, the SPRA process will contribute to the development of a new Health and Wellbeing Strategy for Fife. A plan detailing how the new Strategy will be developed (including stakeholder engagement) is due in June 2021. NHS Fife's Board is expected to approve the Strategy in March 2022.

18. Part of the SPRA process is to develop a medium-term financial plan, recognising and prioritising investment and disinvestment opportunities. The medium-term financial plan is intended to address the £13.6 million health legacy savings by 2023/24 through the SPRA process. Achieving this level of recurring savings will require transformational change. Investment of £500k in a Programme Management Office (PMO) has been agreed to coordinate change projects and recruitment is in progress to secure a Programme Management officer to oversee delivery of the project. The SPRA process is at an early stage and significant work is required to achieve the level of change and savings required.

Refer to Exhibit 1. Action Plan no. 5

Financial sustainability

19. NHS Fife had been planning to meet 90% of its efficiency savings targets for 2020/21 through delivery of its transformation programme, but this programme has been paused for the last year as priorities have been redefined by the Scottish Government in responding to the pandemic.

20. NHS Fife are currently reporting an in-year budget gap of £8.2m for 2021/22, and a total gap of £21.8 million. NHS Fife has assumed that Scottish Government will fund the pressure in 2021/22, caused by unachieved savings brought forward from 2020/21, however this has not yet been confirmed (para. 13).

Refer to Exhibit 1. Action Plan no.6

Risks identified

21. The key issues identified during the interim audit are detailed in Exhibit 1. These findings inform our approach to the 2020/21 financial statements audit.

22. Our review identified a control weakness regarding changes to suppliers bank details. This control is not considered to be a key control or represent risks of material misstatement and therefore, does not have an impact on our audit approach. However, this weakness has been discussed with management to ensure it is addressed to improve the internal control environment.

Additional audit work due to systems weaknesses

23. Interim testing has identified systems weaknesses which require us to reconsider our audit procedures. Control weaknesses increased in payroll validation and exception reporting, processing of journals, and checks performed on the validity of payments made to FHS primary care practitioners due to Covid-19, leading to reduction in the operation of financial controls during the year:

24. We assessed that these weaknesses do not represent additional risks of material misstatement, but we have identified a need to undertake additional audit work during our financial statements audit as follows:

- We will substantively test a sample of paid employees in Acute Services to ensure they exist as current employees of the NHS Fife, through confirmation to other records. We will also select a sample of leavers and ensure they have been removed from the payroll and that they have not continued to be paid after their date of leaving NHS Fife. (see Exhibit 1. Payroll validation)

- We will select an extended sample of journals using GliQ (our journal risk assessment tool) and substantively test these to ensure only valid transactions have been processed. (see Exhibit 1. Authorisation of journals)

- We will test compliance with revised guidance relating to payment verification procedures issued by Scottish Government Health and Social Care Directorate during 2020/21. We will also obtain and review the service auditor report and external auditor assurances for NSS, revising our audit

approach as necessary. (see Exhibit 1. FHS - payments to primary care practitioners)

- We will test a sample of Pecos payments processed by the user for whom we were unable to confirm access had been authorised to confirm entries are appropriate. (see Exhibit 1: Pecos access controls).

Exhibit 1
Key findings and action plan 2020/21

Issue/ risk (Year first reported)	Recommendation	Agreed management action/ timing
1. Changes to supplier details We have reported in prior years that there has been no agreed or consistent procedure for verifying changes to supplier details. During 2019, management addressed this control weakness and confirmed new procedures with relevant staff. We tested changes to supplier details in 2020/21 and found some instances where staff had not followed the revised procedures management had implemented in 2019/20. **There is a risk of exposure to fraud.**	Agreed procedures need to be documented and complied with to ensure changes to supplier details are checked consistently and in accordance with the requirements of management.	Review of supplier details process is currently under review and will be complete in line with the wider review of financial operating procedures
2. Payroll validation (Staff list verification exercise) We performed a review of the annual payroll validation exercise which confirms the existence of employees on the payroll. We found that: • the overall response rate was 79%, which is seven percent lower than last year. The response rate for acute services was particularly low at 59%. • for a sample of reports sent out and returned, action had been taken to process amendments highlighted by managers. However, one amendment had been processed three months after it had been notified, and we could not identify when two other amendments had been processed or whether any overpayments had occurred.	Controls require to be implemented to ensure there is a complete audit trail of all amendments processed and that all leavers are removed from the payroll timeously.	The control document used to record issues and returns for the staff verification exercise will be enhanced to include any areas highlighted by Budget holders and the action taken by the appropriate member of the Financial Management Team. This will be done to ensure that there is an audit trail and if the amendments involve staff leavers, then that the appropriate line manager has been informed so all appropriate entries can be carried out through our eESS System and then actioned through payroll.

There is a risk that payments are made to people who are not employed by NHS Fife.		
3. Authorisation of journals We tested 20 journals and for three we were unable to obtain evidence that they had been appropriately authorised. We also identified one user with access to the general ledger who left in March 2021, but where IT access rights were still in place in May 2021 **There is a risk of fraud and error.**	Management should ensure all staff are familiar with procedures for authorising journals and ensure controls are in place to control/ detect those which have not been properly authorised.	Management have reviewed the process to ensure a common approach across the Finance Team. All staff in bands 3 and 4 will need to have their journals signed off before they can be uploaded either through EFIN or backup email, to provide appropriate evidence.
4. FHS - payments to primary care practitioners Covid-19 impacted on suspending counterfraud activity on payments to primary care practitioners, and meetings between NHS Fife and representatives from the Practitioner Services Division of NHS National Services Scotland to monitor payment verification work for medical, dental and ophthalmic. Covid-19 also resulted in weaknesses in payment verification controls designed to ensure the accuracy and validity of payments to medical, dental and ophthalmic practices. **There is a risk of fraud and error.**	NHS Fife should ensure compliance with revised guidance relating to payments and payment verification procedures issued by Scottish Government Health and Social Care Directorate during 2020/21. Consideration of the implications of service auditor report for PSD prior to September 2021.	In line with SG directive, Health Boards have continued to pay practices their Enhanced Services payments based on historic data in recognition that activity will be greatly reduced and they should not be disadvantaged. As such the payment verification on this becomes unnecessary as the payment will not marry up with the activity so there is no tangible benefit in carrying out these checks. Once the payment of Enhanced Services returns to the normal process and the practice visits can be undertaken safely then these services will be stepped up again. During the Covid-19 period additional payments have been made to practices to reflect the increased costs borne, for example, as a result of additional cover for staff in isolation, upgrades to the practice infrastructure to manage the new ways of working or

		improvement to the building to improve infection control. These payments have been verified either by the Health Board or Medical PV staff to ensure that claims are in line with SG guidance.

Wider dimensions – key findings

5. Medium term financial plan NHS Fife does not have a medium-term financial plan and continues to rely on non-recurring savings to deliver against their financial targets. Work is progressing on developing a Strategic Planning and Resource Allocation process which includes a medium-term financial plan but this is currently in its early stages. **There is a risk that NHS Fife will be unable to deliver the savings required to achieve a balanced budget on a recurring basis over the three-year planning and performance cycle.**	NHS Fife should prioritise development of its medium-term financial plan to ensure savings are identified, and a balanced budget is achievable on a recurring basis over the three-year planning and performance cycle.	NHSF has presented a medium-term savings profile over 3 years. Ongoing work on our Population Health and Wellbeing Strategy will further inform our 3 year plan. During 2021/22 SG plan to revisit the medium term financial planning arrangement. We will integrate our service transformation work with our medium term financial planning work.
6. Service transformation NHS Fife had been planning to meet 90% of its efficiency savings targets for 2020/21 through delivery of its transformation programme, but this programme has been paused for the last year as priorities have been redefined by the Scottish Government in responding to the pandemic. Delaying the transformation of services presents a risk to future financial sustainability and delivery of performance targets.	NHS Fife should recommence work on its transformation programme as soon as it is feasible to do so.	As part of our 2021/22 financial planning process, a list of in-year recurring planned savings has been identified, agreed, and is in progress. A further medium term strategic savings programme identifying potential areas which will drive cost reduction is in progress; and will be underpinned by our PMO service transformation focus. In addition dialogue has commenced with SG re our case for NRAC funding parity.

Source: Audit Scotland

25. All our outputs and any matters of public interest will be published on our website: https://www.audit-scotland.gov.uk.

NHS FIFE

Management report 2020/21

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NHS Fife

Meeting:	**NHS Fife Audit and Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Risk Management Leadership**
Responsible Executive:	**Margo McGurk, Director of Finance and Planning**
Report Author:	**Gemma Couser, Head of Quality and Clinical Governance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

This aligns to the following NHS Scotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

In May 2021 the Executive Directors Group endorsed the paper set out in appendix 1. Approval of the paper and associated funding allows NHS Fife to progress a clear separation of risk management arrangement from those in relation to adverse events/organisational duty of candour. This funding will allow for the creation of a fixed term post to lead on adverse events and duty of candour, allowing the Risk Manager to focus on the further development of NHS Fife's Risk Management Framework. It should be noted that adverse events is a critical component of NHS Fife's clinical governance structure and a fixed term post has been progressed to allow for a review of the process and policy before substantive recruitment is pursued.

2.2 Background

NHS Fife is committed to embedding a risk management culture which:

- Ensures the safety of patients and staff
- Fully integrates risk management with the strategic planning process
- Foresees operational, financial and strategic risks that may comprise delivery of organisational objectives through proactive planning and mitigation

- Is supported by an effective and visible risk management framework which is used proactively across the organisation from ward to Board

2.3 Assessment

The additional resource allowing for a focus on risk management will elevate the profile of risk management through integration with the strategic planning process. This is particularly critical given the launch of the Strategic Planning and Resource Allocation (SPRA) process and the development of the NHS Fife Population Health and Wellbeing Strategy.

The requirement to provide a dedicated focus on Risk Management has also been identified by Internal Audit.

2.3.1 Quality/ Patient Care

Ensuring dedicated and focussed resource is in place to deliver effective risk management supports delivery of high-quality in-patient care.

2.3.2 Workforce

The addition of the fixed term post to support the management of adverse events and organisational responsibilities in relation to duty of candour will improve the effectiveness of current arrangements.

2.3.3 Financial

Funding for the fixed term post in 2021/22 will be drawn from the planned investment priority in relation to enhancing corporate governance arrangements and the corporate PMO.

2.3.4 Risk Assessment/Management

The proposal will enhance and deliver more focus in ensuring the effectiveness of our risk management arrangements.

2.3.5 Equality and Diversity, including health inequalities

There is no impact in this area.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The proposal has been development through engagement with the Clinical Governance team.

2.3.8 Route to the Meeting

This paper was previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- EDG, 6 May 2021.

2.4 Recommendation

- **Awareness** – For Members' information only.

The Audit and Risk Committee are recommended to note this change.

3 List of appendices

The following appendices are included with this report:

- Paper presented to EDG

Report Contact
Gemma Couser
Head of Quality and Clinical Governance.
Email gemma.couser2@nhs.scot

NHS Fife

Meeting:	**Executive Directors Group**
Meeting date:	**6 May 2021**
Title:	**Risk Management Leadership**
Responsible Executive:	**Dr Chris McKenna, Medical Director and Margo McGurk, Director of Finance and Strategy**
Report Author:	**Gemma Couser, Interim Head of Quality and Clinical Governance**

1 Purpose

This is presented to EDG for:

- Decision

This report relates to a:

- Annual Operational Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Fife is committed to embedding an effective risk culture. This paper sets out a proposal to elevate the profile of risk management through integration with the strategic planning process.

2021/2022 will see a reset across NHS Fife with two key strategic workstreams being progressed:

1. In the last financial year a new consolidated and system wide Strategic Planning and Resource Allocation (SPRA) process was launched. The SPRA is intended to create a planning and resource allocation framework to support the development and delivery of a 3 year organisational plan for NHS Fife. This collaborative approach will identify priorities and ensure alignment of resource to deliver these across the full organisation including the Health and Social Care Partnership.

2. Refresh of the Clinical Strategy for NHS Fife which will transform into a Health and Wellbeing Strategy for NHS Fife, with NHS Fife aspiring to become an Anchor Institution.

In order to deliver these crucial workstreams it is paramount that organisational risk management is fully integrated in the process.

Effective risk management arrangements will contribute to successful delivery of these two workstreams through:

- Supporting operational teams to identify and manage operational risks effectively;
- Alignment with the SPRA process to identify organisational risks to assist in informing organisational objectives;
- Identifying risks which may comprise delivery of the objectives;
- Managing and foreseeing risks generated through delivery of the Health and Wellbeing Strategy and;
- Supporting the organisation to identify possible opportunities for innovation.

Currently the organisational ability to deliver an integrated approach to risk management and strategic planning is limited due to the workload associated with supporting the management of adverse events, in particular those graded major and extreme. The latter has dominated and compromised the ability of the Risk Management Team to deliver on activities relating to risk management. It is therefore necessary to ensure a clear separation of risk management and adverse events/ duty of candour (DoC). This requirement has also been recognised in Audit Report B13/2020, Risk Management Staging Report.

2.2 Background

Risk Management in NHS Fife

NHS Fife is committed to embedding a risk management culture which:

- Ensures the safety of patients and staff
- Fully integrates risk management with the strategic planning process
- Foresees operational, financial and strategic risks that may comprise delivery of organisational objectives through proactive planning and mitigation
- Is supported by an effective and visible risk management framework which is used proactively across the organisation from ward to Board

Resource and Leadership for Risk Management

The Senior Responsible Officer for Risk is the Director of Finance and Strategy. The Risk Manager is managed within the Quality and Clinical Governance Team which is responsible for the following portfolio:

- Clinical Effectiveness- including patient safety

- Cancer Audit, Performance and Strategy
- Risk Management
- Adverse Events

The increasing workload of the team with no corresponding investment has necessitated continual review of workload in order to deliver both service objectives and new developments. The team structure of the Risk management team is summarised below:

Post	Band	WTE
Risk Manager	8a	1.0
Risk Management Coordinator	6	1.0
Risk Management Coordinator	6	0.91
Datix Administrator	4	0.75
Risk Management Assistant	3	1.0

The portfolio aligned to the Risk Management Team consists of:

- Supporting the management of adverse events across the organisation
- The development of systems and processes to support the implementation of organisational duty of candour
- The development and implementation of the Board Assurance Framework
- Developments within risk management and the risk management system
- Provision of reports to groups and committees
- System administration of Datix
- Provision of a range of training (Datix, adverse events, in-house core)
- Committee and group attendance and support
- Participation in and links with national networks

In recent years the workload of the Risk Management Team has been impacted significantly due to the growing workload associated with adverse events and DoC.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach is paramount in supporting the organisation to achieve strategic priorities. To achieve this state and improve on the current position, additional resource is required (as outlined in section 2.4). This would to deliver the:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

To achieve the work outlined above an options appraisal has been undertaken and is summarised in the table below:

Description of Option		Benefits	Limitations	Cost (top of scale and assumes 4% applied for 21/22)
1	Do nothing	No financial cost	The organisation will not be able to deliver the risk management objectives stated in this paper.	0
2	Recruit temporary (12 months) band 8a Adverse Events (and Organisational Learning) manager to lead on adverse events, releasing the existing Risk Manager. Conduct review of adverse events and re-evaluate at month 8.	Temporary post offered as a secondment allows changes to be implemented quickly in line with strategic planning timescales for this fiscal year. Adverse events element of the Risk Manager's role would be addressed in full allowing the Risk Manager to focus on the further development of NHS Fife's Risk Management Framework Temporary nature of the post allows for the review to be conducted to ensure the structure of the team meets organisational need. Financial risk is reduced	Financial implication	£74,129
3	Recruit band 7 to support Risk Manager in delivering adverse event workload	Will address in part the current workload pressures associated with adverse events	Financial implication Post will not fully address the adverse event workload and will require input from the Risk Manager	£63,130

Description of Option		Benefits	Limitations	Cost (top of scale and assumes 4% applied for 21/22)
			which will continue to comprise the ability to deliver the organisational risk management objectives stated	
4	Recruit substantive band 8a Adverse Events and Organisational Learning Manager to release Risk Manager.	Adverse events element of the Risk Manager's role would be addressed in full allowing the Risk Manager to focus on the further development of NHS Fife's Risk Management Framework	Financial implication Increased lead time due to substantive recruitment Provides less flexibility for structure change following review of adverse event process	£74,129

It is recommended that option 2 is supported and progressed with a view to having this implemented by the end of May 2021.

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife would support the development of the quality and patient safety agenda through improved operational governance and strategic planning.

2.3.2 Workforce

The most notable effect will be for the Risk Manager, who has contributed to the development of this proposal and is supportive of the recommendation.

2.3.3 Financial

Investment of £74,129 for 12 months is required to deliver the recommended way forward. The funding source for this proposal is to be determined.

2.3.4 Risk Assessment/Management

The current situation is not sustainable and will not allow NHS Fife to fully embed an effective risk management framework and culture to support the achievement of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

The separation of risk management and adverse events will have a beneficial impact of providing equal focus on these respective fundamental activities.

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with the following key stakeholders:

- The Risk Manager
- Director of Finance and Strategy
- Medical Director
- Head of Quality and Clinical Governance

2.3.8 Route to the Meeting

This paper has been developed in collaboration with stakeholders set out above.

2.4 Recommendation

EDG is recommended to support option 2.

Report Contact
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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Update on NHS Fife Board Assurance Framework**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. The BAF integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance. This is an update since the last report to the Committee on 13 May 2021.

2.2 Background

This paper fulfils the requirement to report, to the Committee on the status of the BAF and on any relevant developments.

2.3 Assessment

The BAF currently has 7 components.

- Financial Sustainability
- Environmental Sustainability
- Workforce Sustainability
- Quality & Safety
- Strategic Planning
- Integration Joint Board (IJB)
- Digital and Information

The risk levels and ratings are summarised in Table 1.

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating Oct/Nov0 2020	Current Level & Rating Dec2020- /Jan2021 20	Current Level & Rating Jan/Feb 2021	Current Level & Rating April / May 2021
1413	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High	12 (3x 4) Mod
1414	**Environmental Sustainability**	High 20	Likely 4	Extreme 5	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High
1415	**Workforce Sustainability**	High 20	Almost certain 5	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High
1416	**Quality& Safety**	High 20	Likely 4	Extreme 5	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High
1417	**Strategic Planning**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	16 (4 x 4) High	12 (3x 4) Mod
1418	**Integration Joint Board**	High 16	Likely 4	Major 4	12 (3 x 4) Mod	12 (3 x 4) Mod	12 (3x4)) Mod	12 (3x4)) Mod
1683	**Digital and Information**	High 20	Possible 3	Major 5	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High

Since the last report to the Committee, the BAF risks have been reported to and considered by the appropriate committees in April and May 2021. This update summarises the key points from the most recent reports. The BAFs are provided separately in appendices.

Key points

Financial Sustainability BAF

The Director of Finance and Strategy reported on the BAF to the Finance, Performance & Resources (FP&R) Committee on 11 May 2021. The BAF current score has reduced from High to Moderate. The score reflects the position for the 2020/21 financial year where, following confirmation of the return of offsetting savings to Scottish Government (SG); and receipt of full funding of unmet Health and Social Care savings, we are on track to deliver a near balanced RRL position.

The position for 2021/22 financial year and beyond remains challenging with an opening budget savings requirement of c£22m for Health Board retained. Whilst we have highlighted in the financial plan for 2021/22 to SG a funding requirement of c£14m for unmet savings, SG plan to review the position as part of a formal quarter one review. The risk level for 2021/22 will be reassessed at the end of quarter one.

Environmental Sustainability BAF
The Director of Property and Asset Management reported on the above to the FP&R Committee on 11 May 2021. Property & Asset Management continue to mitigate the risks in this area. There has been no substantive change to this BAF.

Workforce Sustainability BAF
The Director of Workforce reported on the above to the Staff Governance (SG) Committee on 29 April 2021; there were no significant changes to the BAF; linked operational risks remain around the National Shortage of Radiologists and Medical Staff Recruitment and Retention.

Quality & Safety BAF
The Medical Director reported on the above to the Clinical Governance Committee (CGC) on 30 April 2021. There has been no substantive change to the BAF. Two linked operational risks have been closed:

- Infusion pumps, volumisers and syringe drivers in Paediatrics and Neonatal Units; and
- Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices.

The Internal Audit plan for 2021-2022 will consider the Quality & Safety BAF in line with assurance mapping principles, and assess whether the risk has been suitably updated to take account of the impact of COVID-19.

Strategic Planning BAF
The Director of Finance & Strategy reported on the above to the CGC on 30 April 2021 and to FP&R on 11 May 2021. This BAF has been updated to reflect the changes over the COVID period, the work underway to develop our strategic planning capacity and capability, and also the development of the new Population Health and Wellbeing Strategy for NHS Fife.

The previous risk which has been in place since 2017 was:

There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost.

The proposed new risk is:

There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

The BAF also describes how the Corporate Objectives have been derived from the Strategic Planning and Resource Allocation (SPRA) process, and the Strategic Priorities form part of the strategic planning direction going forward for NHS Fife. The current risk level has reduced from High to Moderate and the target risk level has reduced from Moderate 12 to Moderate 9.

Digital and Information BAF
The Medical Director reported on the above risk to the CGC on 30 April 2021. The title has changed **from** eHealth Delivering Digital and Information Security **to** Digital & Information.

The risk level and target level remain high and moderate respectively. Since the last report to the Board, two risks are no longer linked to the BAF:

- Inability to audit nhs.scot mail accounts - risk closed as audits and monitoring in place.
- Deliberate unauthorised access or misuse to email by outsiders (Hackers etc.) - risk reduced to 'moderate' after review based on implementation of improved security software upgrades and improvement in 'exposure' scores.

The assurance mapping exercise being undertaken on this BAF has been reinstated, although at a slow pace due to COVID.

Integration Joint Board (IJB) BAF
Following the review of the integration scheme by representatives from NHS Fife, Fife Council and the HSCP, and feedback on same in February 2021, a review letter from the Chief Executives of Fife Council and NHS Fife was sent to Scottish Government (SG) on 24 March 2021 advising on the progress being made in Fife, and highlighting the revised timeframes in line with the impact of the pandemic. The current scheme remains in place until the updated scheme is formally submitted.

Following the submission to SG, discussions have taken place with the Chief Officer of the IJB and the Chief Executives of Fife Council and NHS Fife. There is a commitment to conclude the review of the Integration Scheme through both Fife Council and NHS Fife governance structures by September 2021.

In view of the fact there is ongoing dialogue with SG and a commitment with partners to conclude by September, the risk remains at a moderate level.

Developments
Over the next 6 months, work will be undertaken to further review and assess the adequacy and effectiveness of the Board's risk management arrangements in order to identify actions necessary to strengthen the assurance mechanisms. This will include:

- assessing the extent to which the organisation's current risk profile aligns with strategic planning; and
- re-assessing the Board risk appetite statement both for the safe and effective delivery of services and also the ambitions within the developing Population Health and Wellbeing Strategy

2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

Risk management is a key component of the Board's Code of Corporate Governance, a core part of each Committee's individual remit and intrinsic to the BAF.

2.3.5 Equality and Diversity, including health inequalities

It is expected, that the assessment of equality or diversity implications is intrinsic to the analysis of the BAF risks and thus reflected in the content of the appendices.

2.3.6 Other impact

Appendices 2, 5, 6 and 7 describe impacts relating to Environmental Sustainability, Strategic Planning, Integration Joint Board, and Digital & Information.

2.3.7 Communication, involvement, engagement and consultation

This report reflects the work of Executive Directors, Non Executives and other stakeholders. A version of this update was provided to Fife NHS Board on 25 May 2021.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 4 June 2021

2.4 Recommendation

The paper is presented for members' information.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability - FP& RC 110521
- Appendix 2, NHS Fife BAF Environmental Sustainability - FP& RC 110521
- Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 290421
- Appendix 4, NHS Fife BAF Quality & Safety - CGC 300421
- Appendix 5, NHS Fife BAF Strategic Planning - CGC 300421 & FP&RC 110521
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB) at 080421
- Appendix 7, NHS Fife BAF Digital and Information - CGC 300421

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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	15/04/2021	30 June 2021	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	LIKELY	MAJOR	16	HIGH	POSSIBLE	MAJOR	12	MODERATE	Current financial climate across NHS/public sector. This risk must now be considered in the context of managing the financial impact of the COVID 19 pandemic.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* We are working towards a balanced position for both core and covid positions for the 20/21 financial year (confirmation of return of offsetting savings to SG; and full funding of unmet Health and Social Care savings received. The position for 21/22 financial year and beyond remains challenging with an opening budget savings requirement of c£22m for Health Board retained. We have signalled a funding requirement of c£14m of unmet savings for the 21/22 financial year however SG will review the position as part of a formal quarter one review. To that end the BAF risk remains at a moderate risk rating level.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement Responsible Person: Director of Finance Timescale: Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the the social care forecasts and the likely outturn at year end.	The response to the COVID 19 pandemic required the organisation to focus all our efforts initially on mobilising the response plan and then on remobilising services; winter and the second COVID 19 peak. The financial impact of COVID 19 is significant however we have now received full funding for 2020/21. Given this funding was based on Q3; and made assumptions for Q4, there is still work to be done to ensure delivery of a balanced position. The funding allocation was: net of the return of offsetting cost reductions; and fully funded unachieved savings. This will allow a budget realignment exercise to take place from Health Delegated to Social Care; and, all things being equal, will all but eliminate the previously reported risk share cost.	POSSIBLE	MAJOR	12	MODERATE	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher
1363	Health and Social Care Integration	Active Risk	High Risk	20	McGurk, Margo
1364	Efficiency Savings	Active Risk	High Risk	20	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active Risk	High Risk	20	McGurk, Margo
1784	Finance (Short Term/Immediate)	Active Risk	High Risk	16	Connor, Nicky
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1846	Test and Protect/Covid Vaccination	Active Risk	Moderate	12	Connor, Nicky

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	26/03/2021	4 June 2021	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	Likely	Extreme	20	High Risk	Likely	Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	Remote	Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	McCormick, Neil
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
735	Medical Equipment Register	Closed Risk			
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk			
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk			
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	Fairgrieve, Andrew
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk			
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk			
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk			
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	Fairgrieve, Andrew

1335	FCON Fire alarm potential faiure	Closed Risk			
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Moderate Risk	10	Wishart, James
1352	Pinpoint malfunction	Closed Risk			
1384	Microbiologist Vacancy	Closed Risk			
1473	Stratheden Hospital Fire Alarm System	Closed Risk			

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																											
16	Ex	11	11	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy.	5	4	20	High	4	4	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Lisa Staff Governance	*Ongoing actions designed to mitigate the risk including:* 1. • Implementation and revision of the Workforce Strategy to support the Clinical Strategy and Strategic Framework. 2. • Implementation and revision of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 - 2022. 3. • Implementation of the NHS Fife Strategic Framework particularly the "exemplar employer" and the associated values and behaviours. 4. • Establishment of a Bronze Workforce Group to consider the impact on the workforce in respect of the EU Exit. Organisational support to affected employees is still being provided and publicised. 5. • Implementation of eESS as a workforce management system within NHS Fife 6. • A revised approach to nurse recruitment has been taken this year, enabling student nurses already in the system to remain in post at point of registration, to maintain service delivery. Initial university liaison sessions held to secure next year's graduates. 7 • Work continues to strengthen the control and monitoring associated with supplementary staffing to identify and implement solutions that may reduce the requirement and costs associated with supplementary staffing, including a single bank for NHS Fife. NHS Fife currently has COVID-19 supplementary staffing resources deployed to support the substantive workforce where the need is greater, thereby reducing external costs on staffing. 8. • NHS Fife participation in regional and national groups to address national and recruitment challenges and specific key group shortage areas, e.g. South East Region Transformation Programme Board, Regional Workforce Group, Physicians Associates Group and International Medical Recruitment campaigns. 9. • NHS Fife Promoting Attendance Group and local Divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity. 10. • Well@Work and staff HWB initiatives continue to support the health and wellbeing of the workforce, facilitating early intervention to assist staff experience and retain staff in the workplace, along with Health Promotion and the OH and Wellbeing Service. This has been expanded to take account of COVID-19 HWB initiatives and with investment in our OH service and strengthening links with the Psychology Service. 11. • The iMatter 2020 cycle has been paused during the COVID-19 pandemic with a Pulse Survey run instead and reports available in December 2020. Staff engagement activity is being evaluated to reflect the impact of the pandemic. 12. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce. 13. • Development of the Learning and Development Framework strand of the Workforce Strategy. 14. • Leadership and Management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels. 15. • Improvement to be achieved in Core Skills compliance to ensure NHS Fife meets its statutory obligations. 16. • The implementation of the Learning Management System module of eESS to ensure all training and development data is captured and to facilitate reporting and analysis. 17. • Continue to address the risk of non compliance relating to TURAS Appraisal. 18. • Utilisation of the Staff Governance Standard and Staff Governance Action Plans,(the "Appropriately trained" strand) is utilised to identify local priorities and drive local actions. 19. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working.	Nil	(1-3) Implementation of the Workforce Strategy and associated action planning to support the Clinical Strategy and Strategic Framework. Actions are currently being reviewed with a view to updating priorities following the impact of COVID-19. (4-5) Implementation of proactive support for the workforce affected by the EU Exit. Early renewal of United Kingdom Visas and Immigration Sponsor Licence and successful application for increase in numbers of Certificates of Sponsorship to support future recruitment activity as required. Communication with and support for recruiting managers. (6) Full implementation of eESS manager and staff self service across the organisation to ensure enhanced real time data intelligence for workforce planning and maximise benefit realisation from a fully integrated information system. (7-8) Strengthen workforce planning infrastructure ensuring a co-ordinated and cohesive approach is taken to advance key workforce strategies including those generated by the current COVID-19 pandemic. This now includes employment of independent contractors, student workforce (medical, N&M etc) to support the COVID-19 Test and Protect and Vaccination Programmes. The Director of Workforce has now convened a Strategic Workforce Planning Group which has been complemented by the establishment of an Operational Workforce Planning Group. A COVID-19 Silver Workforce Group was also stood up and down to support workforce demand and supply. These groups will take account of recent and anticipated Scottish Government guidance on Integrated Workforce Planning and are reflected in the recent Interim Workforce Template for NHS Fife and HSCP, based on an integrated approach. (9-10) Continue to support the implementation of the Health & Wellbeing Strategy and Action Plan, aimed at reducing sickness absence, promoting attendance and staff health and wellbeing. Lessons to be learned from COVID-19 health and wellbeing activities and initiatives and the continuation of these supports in the long term and from investment in our OH service. (11) Optimise use of iMatter process and data to improve staff engagement and retention. As agreed Nationally, a Pulse Survey ran instead of iMatter in September 2020, Directorate and Board level reports were available in December 2020, with relevant managerial actions being considered, but will	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Forums and Staff Governance Committee 2. Delivery of Staff Governance Action Plan is reported to EDG, APF and Staff Governance Committee	1. Use of national data 2. Internal Audit reports 3. Audit Scotland reports	Full implementation of eESS will provide an integrated workforce system which will capture and facilitate reporting, including all learning and development activity.	Overall NHS Fife Board has robust workforce planning and learning and development governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, in particular the Workforce Strategy supporting the Clinical Strategy and the implementation of eESS, should provide appropriate levels of control.	2	2	4	Low	Continuing improvement in current controls and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk from moderate to low.

																		not include team reports. (12) Continue to implement and promote Staff Governance Action Plans and staff engagement, through the Pulse Survey results in 2021. (14) Implementation of the Learning and Development Framework strand of the Workforce Strategy. Increased utilisation of virtual learning opportunities. (15-16 & 19) Review of L&D processes, planning and resources to ensure alignment to priorities. (17) Full roll out of Learning Management self service (18) Continuing implementation of the TURAS Appraisal Improvement and Recovery Plan throughout the Board, led by EDG. Responsible Person: Director of Workforce / Partnership Responsible Person: Director of Workforce									

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Dobson, Claire
1324	Medical staff recruitment and retention	Active Risk	High Risk	16	Kennedy, John
90	National Shortage of Radiologists	Active Risk	High Risk	16	Dobson, Claire

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
503	Lack of capacity in Podiatry Service unable to meet SIGN/ NICE Guidelines	Risk Closed			503
1042	Staffing levels Community Services East unable to meet staffing establishment	No longer high risk	Moderate 12	K Nolan	1042
1349	Service provision- GP locums may no longer wish to work for NHS Fife salaried practices	Risk Closed			1349
1353	Medical Cover- Community Services West- expected shortfalls on nurse staffing and GP cover	Risk Closed			1353
1375	Breast Radiology Service	No longer high risk	Moderate 12	M Cross	1375
1420	Loss of consultants	No longer high risk	Moderate 12	H Bett	1420

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	30/12/2020	30/04/21	There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4 – Likely – Strong possibility this could occur	5 – Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 – Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan for clinical services These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Patient Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm. 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level. 4.Risk Management Framework has been updated but to be rolled out.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 4..Review the coverage of mortality & morbidity meetings in line with national developments and best practice guidance 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes. 6. Review annually, all technology & IT systems that support clinical governance e.g. Datix, Formic Fusion Pro. 7. Review our position against the Quality of Care Framework and understand our state of readiness. 8. Further develop the culture of person centred approach to care. 9. Only Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives'.	1. Assurance statements from clinical & clinical & care governance groups and committees. 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. Accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs. 7. External agency reports e.g. GMC 8. Quality of Care review	1. Internal Audit reviews and reports 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) 10. Patient Opinion 11. Specific National reporting	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.We require additional assurances that there is a system in place for oversight of actions from a variety of sources e.g. audit, adverse events, SPSO. 3.We require additional assurances that there are systems in place for oversight of operational risks.	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 – Unlikely – Not expected to happen – potential exists	5 – Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	McCormick, Neil
43	Vascular access for haematology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
521	Capacity Planning	Active Risk	High Risk	16	Watts, Miriam
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Active Risk	High Risk	16	Shepherd, Angie
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Active Risk	High Risk	15	Anderson, Jane
1670	Temperature within fluid storage room within critical care.	Active Risk	High Risk	15	Watts, Miriam

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk			
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk			
356	Clinical Pharmacy Input	Closed Risk			
528	Pandemic Flu Planning	Active Risk	Moderate	12	Milne, Dona
637	SAB LDP standard	Active Risk	Moderate	9	Cook, Julia
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk			
1366	T34 syringe drivers in the Acute Division	Closed Risk			
1502	3D Temperature Monitoring System (South Lab)	Closed Risk			
1524	Oxygen Driven Suction	Closed Risk			

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	03/03/2021	1 July 2021	Proposed New Risk There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Remove Historic Risk(s) There is a risk that NHS Fife will not deliver the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost with the consequence that the Clinical Strategy does not reflect current priorities. Key Risks 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	Likely	Major	16	High risk	Unlikely	Major	12	Meduim risk	The Board remains under the direction of Scottish Government will clear priorities established for 2021/22. The RMP3 sets out those priorities and is likely to be reviewed in September 2021.	Margo McGurk Director of Finance	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 20/4/21 1. NHS Fife has commenced the development of an approach and timeline to deliver a new Population Health and Wellbeing Strategy by 31 March 2022. 2. Investment in redesigning our programme management capacity and capability and governance has been prioritised through the Strategic Planning Resource Allocation (SPRA) process. 3. Development of corporate objectives is ongoing and has been informed through the 2021/22 SPRA process.	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	EDG will engage in monthly sessions to ensure the ongoing development of the new strategy. The NHS Fife Board and Governance Committees will be fully engaged in this process throughout 2021/22 and will be responsbile for approval of the emerging strategy. Work is ongoing to develop clarity on the system-wide governance arrangements in terms of the developing strategy. Joint sesssion planned with NHS Fife and Fife Council Executive Teams for May 2021. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance Committeee scrutiny and reporting.	Governance of new arrangements will be agreed to deliver the required assurance.	Work is ongoing to agree the corporate objectives through SPRA process and the development of the Population Health and Wellbeing Strategy. This will be supported by the corporate PMO.	Unlikely	Moderate	9	Low risk	-

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
1676	Sustainable	09/04/2021	04/06/2021	There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	The level of risk has been actively reviewed and, following feedback from colleagues, as there is considerable work ongoing to support the conclusion of the review and this is being regularly monitored, the risk score has been maintained at a moderate level	Nicky Connor Director of Health & Social Care	NHS Fife Board. Tricia Marwick.	*Ongoing actions designed to mitigate the risk including:* 1. IJB reviewed its Integration Scheme in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 2.The revised NHS Fife Code of Corporate Governance was approved by the NHS Fife Board in March 2018. 3. A Code of Corporate Governance for the IJB was approved in June 2018. The IJB Code of Corporate Governance forms part of a consolidated governance framework, including an action plan and assurance map. This will ensure all risks, responsibilities and other appropriate matters are understood by all parties and considered effectively for ongoing assurance and the annual Governance Statement. 4. A Governance Manual, bringing all relevant governance information in to one reference document for all IJB members and officers is currently being finalised. 5. Key recommendations and proposals from the Audit Scotland report of November 2018 and the Ministerial Strategic Group review of February 2019 were considered by the IJB and its partners. An integration stocktake self assessment was submitted to the Scottish Government in May. Subsequently an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The Action plan sets out actions to improve governance arrangements including initiation of discussions with partners to provide further clarity on the Integration Scheme. 6. A group, including representatives from NHS Fife, Fife Council and the HSCP, was set up to review the Integration Scheme. This review will focus on governance arrangements and take into account the actions from the Ministerial Strategic Group action plan and also the Scottish Government's Model Scheme for Integration. Following the review of the Integration Scheme the IJB will undertake a further review of its Governance Framework and structures. 7. A development session for officers and IJB members was held in Nov 2019. This was facilitated by David Williams, Director of Delivery, Health and Social Care Integration, Scottish Government and focussed on Governance. A programme of development days has been progressed since May 2020. Four sessions have been completed to date with further sessions planned. Topics covered include: Governance, Directions, Roles and Responsibilities, the IJB Annual report, Remobilisation of Services, Leadership and Structures, Best Value and Performance. 8. Feedback on the revisions to the IS was received from NHS Fife and Fife Council in February 2021. These have mostly been agreed and concluded with the exception of an element of the Finance Section. 9. A review letter from the Chief Executives of Fife Council and NHS Fife was sent to the Scottish Government on 24 March 2021 advising on the progress being made in Fife and highlighting the revised timeframes in line with the impact of the pandemic. The current scheme remains in place until the updated scheme is formally submitted. A meeting is arranged with the Chief Officer of the IJB and the Chief Executives of Fife Council and NHS Fife to agree the timescale for conclusion through formal governance structures. 10. An update on this position was taken to a private session of NHS Fife Board on 31 March 2021. 11. In view of the fact there is ongoing dialogue with Scottish Government and partners, the risk remains at a moderate level	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife.	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	1 – Remote – Can't believe this event would happen	4 – Major	4	Low Risk	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
16	Clinical Effective	2	3	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	Likelihood (Initial)	Consequence (Initial)	Rating (Initial)	High	Likelihood (Current)	Consequence (Current)	Rating (Current)	High	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMO	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Strategic Framework and Clinical Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with ongoing review 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning 6. Operational governance lead through SLT focussing on operation controls, lifecycle management, policy/procedure implementation and adherence 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance. 9. FOI, records management, DPA 10. Senior Management Team consideration of policy and procedure impact and associated implementation 11. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 12. Performance Review 13. Participation in national and local audit e.g. NISD Audit 14. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 15 Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 16. Business Case development to include costed resilience by design and ongoing support activities. 17. Enhancing monitoring of our digital systems.	Lack of long term financial, lifecycle and workforce planning - plan to address is in development (Target October 2021) Lack of systems to maintain ongoing monitoring of compliance with the key controls: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target June 2021) NIS Directive - Improvements to be planned following April 2021 Audit feedback Cyber Essentials Plus - Incorporated in NIS D Audit Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021 Governance and procedures do not fully follow ITIL professional standards - Await Internal Audit Findings	1. Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment 2. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Target October 2021) 3. Ensure existing systems are considered first prior to new systems introduced without sufficient skilled resources to maintain on an ongoing basis. The continual use of business case development and governance of digital request by D&I Board will support this mitigation 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. Accreditation systems. 11. Locally designed subject specific audits. 12. Update to Assessment following June 2019- Digital Maturity Assessment	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now being progressed - target completion July 2021 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. Assurance reports are consistently provided to D&I SLT monthly and development of data reports to Governance Groups continue to be developed. Well developed reporting, which can highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 3. As the requirements are defined the reporting is developed accordingly and then undergoes consistent review. Implementation of improvements as recommended in Internal and external Audit Reports and an internal follow-up mechanism to confirm that these have addressed the recommendations made. 4. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 5. Output from national Digital maturity is	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 5. Engagement with EDG in relation to FOI compliance (February 2021) 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	Unlikely	Extreme	Moderate	Moderate	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	Young, Allan
1338	End of support lifecycle for Microsoft Office 2007	Active Risk	High Risk	16	Young, Allan
1424	End of support lifecycle for Microsoft Server Products	Active Risk	High Risk	16	Young, Allan
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1934	Loss of Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1746	O365 May Cause Disruptive Network Overhead	Active Risk	High Risk	16	Young, Allan
1393	Patch Management Risk	Active Risk	High Risk	16	Young, Allan
1576	Risk of not meeting SaMD full compliance	Active Risk	High Risk	16	McKenna, Christopher
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1927	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Active Risk	High Risk	16	Fowles, Malcolm
1932	T4 - User error (including those supporting system)	Active Risk	High Risk	16	Fowles, Malcolm
537	Failure of Local Area Network causing loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
913	MIDIS replacement	Closed Risk			
1928	T2 - Deliberate unauthorised access or misuse by outsiders (e.g. hackers)	Active Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk			

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 June 2021**
Title:	**Update on Corporate Risk Register arrangements**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to EDG for:

- Discussion

This report relates to an:

- Local Framework & Policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Since 2017, the Board Assurance Framework (BAF) has superseded the Corporate Risk Register (CRR) as the key document subject to governance committee and Board scrutiny in NHS Fife. The CRR is to be reinstated in 2021 as a key component of the Board's risk management arrangements.

2.2 Background

EDG are currently sighted on risks linked to the BAF before these are submitted to the governance committees, and also receive a monthly report on COVID - 19 related high risks.

It has been agreed, that going forward, EDG will be informed of **all** active high risks or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate, and consider these for inclusion on the CRR and / or as a linked risk on the BAF, or decide on another course of action.

2.3 Assessment

The CRR currently contains 5 risks; 3 high and 2 moderate. See Appendix 1.

Going forward, the CRR will be scheduled for monitoring and review as part of the EDG Business agenda in accordance with the Executive Directors' Group Annual Workplan.

2.3.1 Quality/ Patient Care

Risk management systems and processes support the delivery of safe, effective, person centred care.

2.3.2 Workforce

The arrangements for risk management are contained within current resource. Effective risk management empowers staff to identify and address risks, make improvements, protect health and wellbeing and reduce staff exposure to risk.

2.3.3 Financial

Proportionate management of risk supports the efficient and effective use of resources.

2.3.4 Risk Assessment/Management

The appendix provides details of the risks, their analyses, and mitigating actions.

2.3.5 Equality and Diversity, including health inequalities

This paper does not raise any specific issues relating to the above.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Communication took place initially in January 2021 with the former Director of Nursing & Executive Lead for Risk Management, and the Chief Executive, and latterly with the Head of Corporate Governance & Board Secretary.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 7 June 2021 and EDG on 10 June 2021

2.4 Recommendation

- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

The following appendix is included with this report:
Appendix 1, Corporate Risk Register at 07/06/21

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

ID	1296	529
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register
Opened	22/08/2016	02/10/2012
Title	Emergency Evacuation, VHK Phase 2 Tower Block	Information Security Risk
Description	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.	There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, affect essential services, loss theft or misuse of paper based records during transportation, clinical processes or storage. This risk relates to the Networking and Information Systems(NIS)Regulations.
Likelihood (initial)	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	5 - Extreme	3 - Moderate
Risk level (initial)	High Risk	High Risk
Rating (initial)	20	15
Current Management Actions	JR - 04/11/2020 - The current management actions/position for this risk are: two tone fire alarm system to allow identification of zone of fire and progression of patients to a safe zone. :Fire response team in place all wit their own pagers, responding to a fire alert automatically. :Clinical coordinators/fire response team trained. :Fire wardens for the site trained.	This risk remains high. NHS Fife is taking steps to identify and risk assess data assets using the DPIA Template, but this involves significant effort to retrospectively complete, this is work in progress. There is ongoing discussion between the CSM and ISM as to the formulation of a work flow for DPIA's to progress through to streamline the process, this will be raised within the IG&S Ops meeting. The NIS regulations audit has been carried out and we await the report, this report will be used to build an action plan of progression towards addressing the information security objectives. CSM and ISM are in process of developing a framework of baseline acceptable standards and documentary requirements that will address information security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks:220,225, 226,230,537,538,540,1410,1569.
Likelihood (current)	4 - Likely - Strong possibility this could occur	4 - Likely - Strong possibility this could occur
Consequence (current)	5 - Extreme	4 - Major
Risk level (current)	High Risk	High Risk
Rating (current)	20	16
Likelihood (Target)	1 - Remote - Can't believe this event would happen	1 - Remote - Can't believe this event would happen
Consequence (Target)	5 - Extreme	4 - Major
Risk level (Target)	Low Risk	Low Risk
Rating (Target)	5	4
Risk Owner	McCormick, Neil	McGurk, Margo
Handler	Ramsay, Jimmy	Irving, Kevin
Previous Review Date	26/03/2021	20/04/2021
Next Review	30/06/2021	20/07/2021

ID	522
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, NHSFBD - Prescribing & Medicines Management Risk Register
Opened	30/03/2006
Title	Prescribing and Medicines Management - Prescribing Budget
Description	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	9
Current Management Actions	30/4/21 - The GP prescribing position for 20/21 is an underspend of £24k (0.03%), on an annual budget of £70.7m. £1.891m recharged to COVID costs, based on final national guidance and local analysis. The analysis and basis of recharge to COVID funding focused on price impact, drug switch requirements (primarily to minimise healthcare contacts)and increased usage, full analysis is available. Hospital prescribing budget is overspent by £1.26m (3.7%), on a budget of £33.77m Medicines efficiency target for 21/22 is £500k for both HSCP and Acute Services (combined £1m). The first meeting of the Fife Prescribing Forum took place on 23 April.
Likelihood (current)	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (current)	3 - Moderate
Risk level (current)	High Risk
Rating (current)	15
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	McKenna, Christopher
Handler	Reid, Euan
Previous Review Date	03/02/2021
Next Review	30/06/2021

ID	1500
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register
Opened	04/12/2018
Title	Cyber Resilience Risk
Description	There is a risk that NHS Fife will be overcome by a targeted and sustained attack because of a lack of Cyber Resilience, resulting in our inability to resist, respond and recover from cyber attacks that may impact the availability or integrity of information we require to operate a full Health Service.
Likelihood (initial)	3 - Possible - May occur occasionally - reasonable chance
Consequence (initial)	4 - Major
Risk level (initial)	Moderate Risk
Rating (initial)	12
Current Management Actions	29/12/2019 - Work continues to develop and improve the Cyber Security Plan and strengthen NHS Fifes overall cyber security posture. This includes work to improve staff awareness of common threats. However, due to the response to COVID-19 and an ongoing heightened state of Threats & Vulnerabilities; progress has been slower than anticipated. The Cyber Security Team has also suffered some retention issues during 2020.
Likelihood (current)	3 - Possible - May occur occasionally - reasonable chance
Consequence (current)	4 - Major
Risk level (current)	Moderate Risk
Rating (current)	12
Likelihood (Target)	2 - Unlikely - Not expected to happen - potential exists
Consequence (Target)	3 - Moderate
Risk level (Target)	Low Risk
Rating (Target)	6
Risk Owner	Potter, Carol
Handler	Young, Allan
Previous Review Date	01/12/2020
Next Review	01/12/2021

ID	527
Position of Risk (Risk Register)	CORPORATE RISK REGISTER
Opened	09/12/2008
Title	Staff Governance - Sickness Absence
Description	Staff Governance - Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the target of 4%.
Likelihood (initial)	4 - Likely - Strong possibility this could occur
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	12
Current Management Actions	December 2020 - The sickness absence rate for the 12 months ending December 2020 was 5.21%, a decrease of 0.42% when compared with the previous 12 months ending December 2019. During the first nine months of the 2020/21 financial year, the average sickness absence rate was 5.11%, a decrease of 0.49% when compared with the equivalent period of the 2019/20 financial year. Although sickness absence levels have fallen in seven of the nine months of the COVID-19 pandemic, it is difficult to draw any specific conclusions from this due to the current pandemic. A range of actions continue to be undertaken to improve absence rates within NHS Fife, with focussed activity being undertaken within all areas of the Board. NHS Fife's Promoting Attendance Group and Review and Improvement panels continue to meet, along with local Attendance Management Groups. Given COVID-19 and Winter pressures, there will be a challenge in maintaining the current sickness absence performance levels. July 2020 - The sickness absence rate for the 12 months ending July 2020 was 5.34%, a decrease of 0.27% when compared with the previous12 months ending July 2019. During this first four months of the 2020/21 financial year, the average sickness absence rate was 4.90%, a decrease of 0.70% when compared with the equivalent period of the 2019/20 financial year. Although sickness absence levels have fallen in the first four months of the COVID-19 pandemic, it is difficult to draw any specific conclusions from this due to the current pandemic. The situation will continue to be monitored as we return to "normal" and restart various Promoting Attendance activities. In the meantime, a range of actions continue to be undertaken to improve absence rates within NHS Fife, with focussed activity being undertaken within all areas of the Board. Promoting Attendance Review and Improvement Panels, Promoting Attendance Groups and local Management Team meetings had been paused during the COVID-19 pandemic, however, activity re-commenced in earnest from July 2020.
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	3 - Moderate
Risk level (current)	Moderate Risk
Rating (current)	12
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	Douglas, Linda
Handler	Cummings, Karen
Previous Review Date	22/09/2020
Next Review	27/07/2021

ID	527
Position of Risk (Risk Register)	CORPORATE RISK REGISTER
Opened	09/12/2008
Title	Staff Governance - Sickness Absence
Description	Staff Governance - Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the target of 4%.
Likelihood (initial)	4 - Likely - Strong possibility this could occur
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	12
Current Management Actions	27/03/2020 - The sickness absence rate for the 12 months ending January 2020 was 5.60%, an increase of 0.20%. When compared to t he position at the end of January 2019. During this first 10 months of the 19/20 financial year, the average sickness absence rate was 5.65%, an increase of 0.26%. When compared with the equivalent period of the 2018/19 financial year. A range of actions continue to be undertaken to improve absence rates within NHS Fife, with focused activity being undertaken within all areas of the Board in terms of the Review & Improvement Panels, Attendance Management Groups and at local Management Team Meetings. These actions, together with input to the wider Health & Wellbeing agenda, via Well at Work, will help to address this multifunctional problem. It is anticipated that the la t the launch of the new Once for Scotland Promoting Attending Attendance policy on 1 March 2020 will secure a fresh impetus, alongside the plan for the Chief Executive and Director of Workforce the chair a new Promoting Attendance Taskforce, specifically focusing on the long term sickness absence. This taskforce is in the process of being set up and Terms of Reference have been drafted. 18/09/2019 - The sickness absence rate for the 12 months ending July 2019 was 5.61%, an increase of 1% when compared to the position at the end of July 2018. During the first four months of the 2019/20 financial year, sickness absence was 5.6%, an increase of 0.69% when compared with the equivalent period of the 2018/19 financial year. As Anxiety, Stress and Depression remains the top reason for sickness absence, the implementation of early referrals to Occupational Health for staff absent due to Mental Health related reasons for absence was implemented. A series of Manager's Occupational Health Drop-In Sessions continue to take place until October 2019, offering bespoke advice and support to managers on OH issues and to assist in the interpretation of Occupational
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	3 - Moderate
Risk level (current)	Moderate Risk
Rating (current)	12
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	Douglas, Linda
Handler	Cummings, Karen
Previous Review Date	22/09/2020
Next Review	27/07/2021

ID	527
Position of Risk (Risk Register)	CORPORATE RISK REGISTER
Opened	09/12/2008
Title	Staff Governance - Sickness Absence
Description	Staff Governance - Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the target of 4%.
Likelihood (initial)	4 - Likely - Strong possibility this could occur
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	12
Current Management Actions	Health reports to help with Attendance Management. NHS Fife have undertaken three Mental Health in the Workplace training sessions for Managers within the Health & Social Care Partnership and Emergency Care Directorate within Acute Services, as part of the support that we are trying to offer Managers in dealing with staff who have Mental Health related reasons for absence. Two Management of Attendance Workshops for managers, OH and staff side colleagues has taken place in April and July 2019, with a further workshop planned for October 2019. 15/03/2019 - The sickness absence rate for the 12 months ending January 2019 was 5.4%, a decrease of 0.19% when compared to the position at the end of January 2018. During the first ten months of the 2018/19 financial year, sickness absence was 5.39%, a decrease of 0.29% when compared with the equivalent period of the 2017/18 financial year. As Anxiety, Stress and Depression remains the top reason for sickness absence, we have recently refreshed the Management of Attendance training with focus on the use of the Attendance Management Resource pack, Return to Work interview and mental health and well-being at work. An additional programme of Mental Health in the Workplace Training supported by HWL Fife is also being explored. A focussed Management of Attendance Workshop for Managers, OH and staff side colleagues is being planned for April / May 2019. 18/09/2018 - There has been a month on month improvement over the last 6 months. The revised trajectory figure is to reach 4.5% by end of March 2019. The current sickness absence is 4.93% as at 31 July 2018. 07/03/2018 - There has been no improvement in the sickness absence rates over the last 10 months. The on-going works to mitigate this risk are continuing. It has been agreed that the trajectory will be revised to 5.5%
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	3 - Moderate
Risk level (current)	Moderate Risk
Rating (current)	12
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	Douglas, Linda
Handler	Cummings, Karen
Previous Review Date	22/09/2020
Next Review	27/07/2021

ID	527
Position of Risk (Risk Register)	CORPORATE RISK REGISTER
Opened	09/12/2008
Title	Staff Governance - Sickness Absence
Description	Staff Governance - Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the target of 4%.
Likelihood (initial)	4 - Likely - Strong possibility this could occur
Consequence (initial)	3 - Moderate
Risk level (initial)	Moderate Risk
Rating (initial)	12
Current Management Actions	for the forthcoming financial year and that this risk should be reviewed again in 6 months time 27/09/17: The NHS Fife sickness absence rate has been above 5% for the first quarter of the 2017/18 financial year. This is an adverse position in comparison with the previous financial year; however, there are on-going works including Review and Improvement Panels within all areas of the Board, monthly training including Managing Mental Health in the Workplace and the results of the recent managerial and staff surveys in the East Division and Corporate Directorates are being considered with appropriate Action Plans developed. Sickness absence is reported to each Staff Governance Committee along with a Well at Work update.
Likelihood (current)	4 - Likely - Strong possibility this could occur
Consequence (current)	3 - Moderate
Risk level (current)	Moderate Risk
Rating (current)	12
Likelihood (Target)	3 - Possible - May occur occasionally - reasonable chance
Consequence (Target)	3 - Moderate
Risk level (Target)	Moderate Risk
Rating (Target)	9
Risk Owner	Douglas, Linda
Handler	Cummings, Karen
Previous Review Date	22/09/2020
Next Review	27/07/2021

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 June 2020**
Title:	**Risk Management Annual Report 2020-2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the group for:

- Awareness

This report relates to a:

- Local framework and policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides the Committee with assurance on the risk management activities undertaken during the period 2020/2021.

2.2 Background

The report forms a component of the governance reporting arrangements for risk management as set out within the NHS Fife Risk Management Framework and in accordance with the risk management component of the NHS Fife Code of Corporate Governance.

2.3 Assessment

The report summarises the range of work carried out in the past year which has contributed to the Board's management of risk including developments in the following:

- Assurance Mapping

- Board Assurance Framework
- Key Performance Indicators
- Adverse events management and organisational duty of candour
- Datix system

2.3.1 Quality/ Patient Care

NHS Fife's risk management system should focus on minimising risk and support safe, effective, person centred delivery. The report refers to activities that support that ambition.

2.3.2 Workforce

Risk management requires all staff to manage risk as part of their daily work.

2.3.3 Financial

No issues identified.

2.3.4 Risk Assessment / Management

The report describes risk management activities that support delivery of the Board objectives.

2.3.5 Equality and Diversity, including health inequalities

Report describes risk management activity and raises no equality and diversity issues.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

NHS Fife Risk Management Team
Gemma Couser, Head of Quality & Clinical Governance, NHS Fife

2.3.8 Route to the Meeting Margo McGurk**,** Director of Finance and Strategy and EDG

2.4 Recommendation

Discussion – Examine and consider the assurances provided in the report and note the areas of continuous improvement planned for 2021/22.

3 List of appendices

Appendix 1 – NHS Fife Risk Management Annual Report 2020 – 2021.

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager, NHS Fife
Email Pauline.Cumming@nhs.scot

NHS Fife Risk Management Annual Report

2020-2021

1. PURPOSE OF REPORT

NHS Fife supports the view that risk management is key to ensuring informed decision making, delivering safe, effective, quality patient care and supporting the efficient and effective use of resources in delivering health care to the people of Fife.

This report provides an overview of the risk management activities carried out during 2020/2021and provides assurance that risk management processes are in place to support the delivery of NHS Fife's strategic objectives. The report also outlines the focus of activity in the coming year.

The Board is asked to note and take assurance from the information provided.

2. RISK MANAGEMENT GOVERNANCE

The Audit & Risk Committee is responsible for assessing the effectiveness of the corporate governance framework and systems of internal control operating across NHS Fife.

Assurance on key strategic risks - quality and safety, strategic planning, digital and information, integration joint board, environmental, financial and workforce sustainability, is provided through Board Assurance Frameworks reports to the Executive Directors' Group (EDG), the governance committees and the Board. Each Committee provides an assurance statement within their annual reports in relation to risk.

3. NHS FIFE RISK MANAGEMENT FRAMEWORK

An update to the Risk Management Framework was approved by Fife NHS Board in September 2020. Arrangements to support implementation, including updating the Risk Register/ Risk Assessment Policy GP/R7, will continue into 2021/22.

3.1 Key Performance Indicators

There are currently 7 indicators. (See Appendix 1). These have been reported as required to the NHS Fife Adverse Events & Duty of Candour Group and the Audit & Risk Committee since September 2020. The KPIs will be reviewed in the next 6 months in line with developments in risk management arrangements and the update of the Clinical Governance Strategy.

4. RISK REGISTERS

4.1 Board Assurance Framework (BAF)

The Board Assurance Framework implemented in 2017, integrates information including controls, mitigating actions, assurances, gaps, linked operational risks and an assessment of current performance. Table 1 details the components of the BAF and the aligned committees.

Table 1	
BAF component	**Governance Committee**
Financial Sustainability	Finance, Performance & Resources Committee (F,P&R)
Workforce Sustainability	Staff Governance Committee (SG)
Environmental Sustainability	F,P&R
Quality & Safety	Clinical Governance Committee (CGC)
Strategic Planning	CGC and F, P&R
Integration Joint Board (IJB)	IJB
Digital & Information (formerly e Health)	CGC

For the period 2020/2021, the high level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high level risks, have been reported as part of the BAF to the EDG, the governance committees, and thereafter to the Audit & Risk Committee and the Board.

The impacts of COVID-19, the remobilisation and reconfiguration of services, and linkages with strategic planning priorities, are also referenced in several BAFs. It is recognised further work is required to ensure these are explicitly articulated in all BAFs.

The application of assurance mapping principles to the Digital and Information BAF was severely impeded due to COVID -19, this work has recommenced during 2021.

The Quality & Safety BAF will be considered as part of a review of Clinical Governance Strategy and Assurance in line with assurance mapping principles in 2021 and will include an assessment of whether the risk appropriately reflects the impact of COVID-19.

4.2 Corporate Risk Register (CRR)

As previously reported, since 2017, the BAF superseded the CRR as the mechanism for reporting risks considered to present a threat to the achievement of the board's objectives. In January 2021, the Executive Lead for Risk Management presented a proposal to the EDG to reposition the CRR as a key component of the board's risk management system. Due to other priorities, it was not possible to fully consider the proposal at that time however this will be progressed in Q3 of 2021.

4.3 Operational Risk Registers

All of the key areas within the organisation continue to maintain risk registers in Datix. Risks are reported and monitored at local and organisational levels, including through performance reviews and via clinical and clinical and care governance structures. Appendix 2 provides a breakdown of active risks by current risk level and risk type.

4.4 COVID- 19

The process established in 2020/21 to identify, review and monitor COVID -19 related risks within the organisation's Pandemic Command structure, continued to operate until the commands were stood down in the spring of 2021; oversight then reverted to the respective senior management teams responsible for Acute Services, Property and Asset Management,

Medical Physics, Pharmacy, Procurement (including Infection Control), Public Health, Social Work & Social Care and Workforce. The high level risks continue to be reported monthly to EDG.

4.5 Assurance Mapping

During 2020/21, the previously reported activities of the short life working group of representatives from the Boards covered by the FTF Internal Audit Service (Fife, Forth Valley, Lanarkshire and Tayside) and chaired by the Chief Internal Auditor, continued. While the group's work was impeded by the pandemic, one outcome was to agree a suite of assurance principles; these are to be proposed for adoption by all governance committees.

5. RISK APPETITE AND TOLERANCE

The Board agreed its risk appetite in November 2019. The risk appetite statement was due for review and update in November 2020. This activity was delayed due to competing priorities arising from the pandemic. The review will take place in Q3 of 2021/22.

6. ADVERSE EVENTS MANAGEMENT

The management of adverse events remains a critical component of the Board's clinical governance arrangements. NHS Fife promotes adverse event reporting and requires that all events, regardless of the severity of harm and who or what is affected, are reviewed in accordance with the NHS Fife Adverse Events Policy GP/I9.

The NHS Fife Adverse Events & Duty of Candour (DoC) Group continues to provide oversight of the development and implementation of local policy on the management of adverse events in accordance with national guidance, and monitors performance in relation to significant adverse events against agreed measures.

6.1 Incident Reporting

Reporting levels have been broadly consistent over the last few years at 16,000 events per annum. The pandemic has had some impact on reporting figures for the period 1 April 2020 to 31 March 2021, with 14,700 incidents being reported. This is in line with lower in-patient numbers and reduced access to other clinical services. Appendix 3 provides a summary of the events reported in Datix for the year.

6.2 Major and Extreme Adverse Events

During 2020/2021, the Risk Management team continued to support the management of major and extreme adverse events, with the Risk Manager and the Head of Quality & Clinical Governance co-ordinating and contributing to Significant Adverse Event Reviews (SAER). Following a pause from January to March 2021 in SAER activity due to COVID, NHS Fife has prioritised cases as part of the 'reset' of SAER activity and to maximise limited resources.

6.3 COVID -19

Monthly reports detailing COVID -19 and latterly COVID -19 vaccination incidents, have continued to be reported monthly to the Directors of Corporate Services and Public Health, the Associate Medical and Nurse Directors of the Acute Services Division and the Health and Social Care Partnership (HSCP).

6.4 Internal Audit Reports B19/20 and B20/21- Adverse Event Management

In response to the Adverse Event Management review B19/20, several improvement actions were agreed to address the recommendations within the report, with updates provided to both the Audit and Risk Committee and Clinical Governance Committee. Audit B20/21 was an extension of that review. The primary focus was to consider the procedures in place to implement actions to address issues identified from adverse event reviews.

The inherent risks associated with the number of actions not implemented were noted and the importance of developing a multi-faceted action plan to improve this position was recognised.

The results of the audit will be shared with services across the organisation and engagement with services is being arranged to ensure agreed improvements are implemented. Actions will be refined through discussion and consultation with stakeholders. Key areas for action are:

- Visibility of Data - Develop a highlight report which shows actions outstanding by area to ensure organisational oversight and enable management teams to monitor implementation of actions and identify any issues. Discussion is required as to where this data is then reviewed through Clinical Governance Structures from service to committees in order to provide consistent assurance on action being taken.

- Datix System - Through consultation with management teams, explore what changes are required within the Datix to ensure: 1. Ease of use of the system; and 2. A failsafe notification process for Leads to oversee allocation of actions. The review will include a review of fields in the Actions module and staff guidance on its use.

- Training and Education - Increase the emphasis in adverse events training on the importance of actions and improvement measures from adverse event reviews.

- Governance & Oversight - Through consultation with management teams, clarify and confirm the visibility, oversight and governance arrangements at service level for the closure of actions following SAERs in order to embed oversight for implementation of actions within clinical governance structures. Additionally, develop a mechanism for reviewing themes of actions at an organisational level that may require an overall organisational response. The Quality and Clinical Governance team will explore the value of regular engagement meetings with services with a view to supporting the SAER process and associated actions to ensure that these are implemented.

- Clinical Governance Strategy - To improve ownership of actions, consideration will be given to amending NHS Fife policy to align to HIS guidance whereby the review makes recommendations to the service to develop an action plan within a specified timescale.

- SAER Process - The importance of reviews and implementation of improvement actions is an integral part of building on a culture of continuous quality improvement. How this can be strengthened will be considered within the refresh of the NHS Fife Clinical Governance Strategy.

A review of the adverse events process will start in June 2021 as outlined below:

- June 2021 - map the current process
- June/July 2021- convene a short life working group with representatives from across the organisation to map out a future state and develop an implementation plan
- Aug 2021- look to pilot any new ways of working
- Sep 2021- update the Adverse Events policy
- Nov 2021- submit new policy through governance structures

6.5 Mental Health Drug- related Deaths Cluster Review Process

A notable example of adverse events improvement work is the further development of the above process. This was initiated in August 2020 in response to a rising number of drug related deaths, a matter of local and national concern, and was therefore a targetted area for improvement. The reviews are carried out following deaths of patients known to Addiction Services at the time of their death, or on the caseload within the 6 months prior to their death.

The reviews are chaired by the Clinical Services Manager of Addiction Services and have multi-disciplinary and third sector membership. External scrutiny is provided through Public Health, Head of Nursing (Fife Wide) and HSCP Clinical Governance team representatives.

The reviews examine the patient's care and treatment, identify good practice and allow staff to elicit themes and trends, creating an opportunity to learn and develop a collective action plan. Emerging themes from the reviews include actions on physical health care, interface with Mental Health services, poly-pharmacy and risk assessment.

6.6 Healthcare Improvement Scotland (HIS) National Notification System

The Board continues to report monthly into the Notification System which HIS set up in January 2020. HIS are collating the data from all NHS boards in order to identify themes and outcomes and to determine if there is scope to introduce national standardisation of the terminology and approach to adverse event review management. This work will inform the forthcoming HIS and NES Joint Commission for Openness and Learning, which aims to 'increase the safety of the care system for everyone'. All data are subjected to statistical analysis by the HIS Data Management and Business Intelligence team (DMBI), based on population size; NHS Fife data does not currently raise any concerns for HIS.

6.7 Organisational Duty of Candour

Organisational Duty of Candour (DoC) for health and social care organisations in Scotland came into effect on 1 April 2018. The purpose of the duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended adverse event resulting in death or harm, as defined in the Act.

During 2020/2021, the Risk Management team continued to support implementation of DoC and the production of the Year 2, NHS Fife Organisational Duty of Candour Annual Report; the latter was reported to Fife NHS Board on 30 September 2020 and published thereafter. The Year 3 Annual Report is in development.

7. DATIX RISK MANAGEMENT SYSTEM

Datix is used in the Acute Services Division and the East, West and Fife wide Divisions of the HSCP. It is the repository for risks, incidents (adverse events), safety alerts, complaints and claims. The system has more than 1200 registered users. The Risk Management team continue to work to develop capability within the organisation to enable ownership, oversight and the effective use of risk management information.

7.1 User Permissions

During 2020/2021, to ensure system efficiency and effectiveness, considerable work was undertaken to quickly realign user permissions to adapt to changing roles in light of the pandemic and then to re-establish them when normal services started to resume.

7.2 Change Control Process

The change control process in relation to system coding and form design changes has been amended following discussion at the Adverse Events & DoC Group; a small 'change approval team' consisting of senior operational managers approve proposed changes to expedite implementation.

7.3 Communications

The DatixWeb Feedback Newsletter, which reports on changes and improvements was paused due to COVID-19 with vital information issued on Staff Link; it has now been reinstated.

7.4 Staff Engagement

To improve the user experience, the Risk Management team respond to feedback on Datix functionality and involve staff in developments to ensure fitness for purpose.

The automated email feedback function in the Incidents module continues to be well received and issues approx 40 feedback emails per day to reporters.

7.5 Datix Module Development

During 2020/2021, a significant amount of work was carried out on Datix as follows:

7.5.1 Risk Register Module

Currently there are 565 active risks recorded in Datix. Appendix 2 provides a breakdown of the risks by current risk level and risk type.

The redesign of this module will be further progressed in the next 6 months with the input of key stakeholders.

7.5.2 Incidents Module

Reporting Options

The Risk Management team worked with staff to improve options including:

- COVID - 19 vaccination
- Fluid and nutrition
- Vascular access devices
- Adult protection
- Equipment and Medical Devices
- Medical gases
- Point of care testing
- National Screening Programme

Equipment including medical devices

In addition to the changes reported last year to enhance the reporting of equipment related events, further work is underway to ensure that medical devices and equipment incident coding comply with changes being introduced by the Medicines Healthcare Regulatory Authority (MHRA) (Yellowcard system) and include coding for software as a medical device.

7.5.3 Complaints Module

Following collaboration with the Patient Relations Team, the module will shortly be renamed to reflect the range of reports it captures, including positive experiences and good practice.

As previously reported, the module allows users wishing to report Learning from Excellence examples. Currently this provision is used by the renal, orthopaedic, general medicine, maternity and sexual health teams. 32 reports have been submitted over the last year.

National Whistleblowing Standards

The NHS Fife Risk Management team continued to work with the Datix Scottish User Group (DSUG), the Scottish Government Workforce Team, Scottish Public Service Ombudsman and Directors of Workforce to design a form to support the reporting of whistleblowing concerns.

To enable compliance with the standards, and in liaison with NHS Fife Human Resources colleagues, a form that can be used to allow managers to securely record concerns on behalf of their team members was introduced into the NHS Fife Datix Complaints module in April 2021. Concerns can be logged at stage 1 and 2 and also escalated within the system. It includes options to record outcomes and to facilitate reporting on themes and trends.

7.5.4 Safety Alerts Module

The Safety Alerts module continues to be used across NHS Fife for the distribution and management of safety alerts including medical device alerts, hazard notices and product recalls. To date 480 alerts have been added to Datix and distributed for action.

Recent changes to the format of alerts issued via MHRA and IRIC are being included in the system coding.

7.6 Future Developments

As previously reported, Datix will not further develop the web versions, and will only offer problem fixes. Datix Cloud IQ is the upgrade path from DatixWeb. The Board is currently considering its approach pending the outcome of national discussions around procurement.

8. RISK MANAGEMENT TRAINING

During 2020/2021, the Risk Management team delivered a range of training. This included:

- Incident Reviewer/Approver
- Adverse Event Reviews
- Risk Registers
- Managing Safety Alerts
- Reporting from Datix
- Customised sessions for services.

Risk management Learnpro modules and user guides are available on Blink. The following user guides were updated during 2020/21:

- DatixWeb Risks - Risk Register Guide
- DatixWeb Incidents - Quick Reference Card Reporter
- LearnPro guide - Reporting an incident
- LearnPro guide - Reviewing an incident

The team has continued to deliver training successfully via Microsoft (MS)Teams during 2020/21.Uptake has continued to be very good with more than 45 sessions delivered and attendance levels remain high due to the easy access to remote training via MS Teams.

9. LEARNING AND SHARING

Learning and sharing continues to occur through the use of learning summaries, newsletters, and in discussions at clinical and clinical and care governance meetings.

In the past year, for example, the Risk Management team has facilitated successful training events with medical staff from Adult Psychiatry supported by medical education and the Deanery, and contributed to clinical governance sessions within Planned Care and Surgery on organisational duty of candour.

Requests from General Surgery and Gynaecology to contribute to their clinical governance sessions in relation to learning from adverse events; are currently being scoped. The Risk Management team has also been invited to participate in Pharmacy lunchtime learning from adverse event sessions in 2021.

10. RISK MANAGEMENT INPUT TO GROUPS AND COMMITTEES

In 2020/2021, risk management input was provided to the following:

- COVID -19 Vaccination Programme
- Divisional Performance Reviews
- Integrated Performance & Quality Report
- Local Partnership Forum
- NHS Fife Safe & Secure Use of Medicines, Policy and Procedures Group
- NHS Fife Medical Gas Committee
- NHS Fife Point of Care Testing Committee

The Risk Management team participated in the following groups:

Local

- NHS Fife Adverse Events and Duty of Candour Group
- NHS Fife Audit & Risk Committee
- NHs Fife Capital Equipment Management Group
- NHS Fife Clinical Governance Committee
- NHS Fife Clinical Governance Oversight Group
- NHS Fife Decontamination Group
- NHS Fife Flu Silver Command
- Fife Health & Social Care Partnership Health & Safety Forum
- NHS Fife Hospital Transfusion Committee
- NHS Fife Infection Control Committee
- NHS Fife Information Governance Operational Group
- NHS Fife Tissue Viability Working Group
- NHS Fife Violence & Aggression Management Forum

National

- Datix Scottish User Group - Chair, Paul Smith, Risk Management Coordinator
- HIS Adverse Events Network
- HIS Expert Reference Group
- MHRA and IRIC national working group - led by MHRA - Standardisation of medical device coding looking at standardising equipment and medical devices incident coding in line with international standards. This group will provide a draft report through NHS National Services Scotland and NHS Healthcare Improvement Scotland once completed.

11. OTHER ACTIVITY

In 2020/21, the Risk Management team contributed to other activities including:

Freedom of Information (Scotland) Act (FOI) - Provision of data to support FOI responses.

12. RISK MANAGEMENT OBJECTIVES 2021/22

In May 2021, the EDG endorsed a proposal and associated funding to allow NHS Fife to take forward a clear separation of risk management activity from adverse events and organisational duty of candour, thus allowing the Risk Manager to focus on the further development of NHS Fife's Risk Management Framework.

Activity in the year ahead will centre on actions to elevate the profile of risk management through integration with the strategic planning process and the development of the NHS Fife Population Health and Wellbeing Strategy. This will require building on a risk culture which is determined by the risk appetite of the organisation and has engaged risk leadership and proactive measures with focus in place to address risks.

Specific objectives are yet to be agreed but will broadly include:

- implementation of a structured approach to the review and management of risks through appropriate governance structures
- aligning the organisational risk profile to the strategic planning agenda
- agreeing the Board risk appetite statement; stating the type and level of risks to be accepted and the balance of risk versus reward
- applying assurance mapping principles to the spectrum of the organisation's business
- promoting a culture that encourages the proactive identification and mitigation of risk from ward to Board
- developing the use of the BAF to address risks which could compromise delivery of organisational objectives / strategic priorities

Appendix 1

Risk Management Key Performance Indicators (KPI)

KPI	
1. All risks are reviewed by the review date and no later than 10 working days of the scheduled review date. • % compliance on 1st of month • % compliance at 10 working days	
2. All risks must have a review date scheduled commensurate with the assessed risk level.	
Very High: 25	at least monthly
High: 15 - 20	at least quarterly
Moderate: 8 -12	at least 6 monthly
Low: 4 - 6	at least annually
Very Low: 1 - 3	at least annually
3. Length of time 'high' and 'very high' level risks have been at that level.	
4. Designated standing committees receive a report aligned to the Board Assurance Framework at every meeting.	
5. % of Decision Making SBAR for Major and Extreme Adverse Events submitted in line with Adverse Events Policy GP/I9 (i.e. to fife adverse events within 5 working days of being reported) 6. • % no harm adverse events closed within 10 days of being reported • % minor and moderate adverse events closed within 60 days of being reported% major or extreme adverse events closed within 90 days of being reported 7. % of LAER and SAER actions completed by target date	

Appendix 2

Chart 1

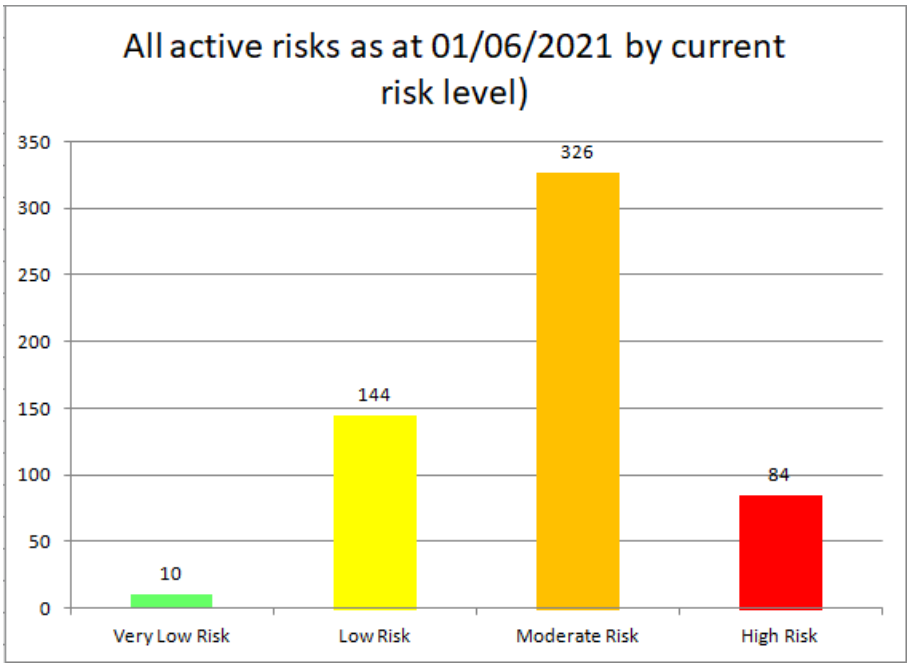
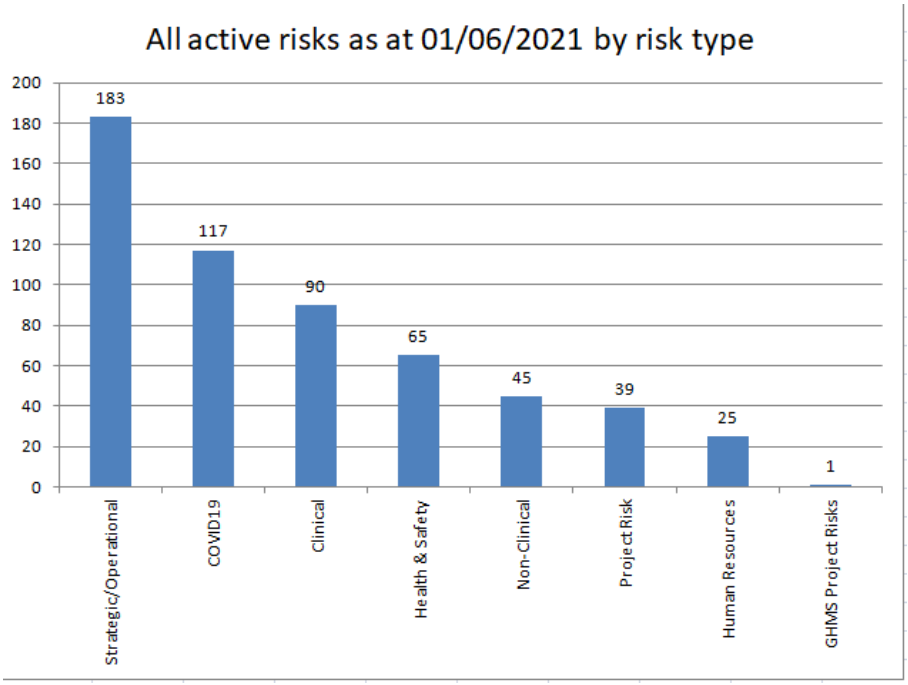


Chart 2



Appendix 3

Chart 1

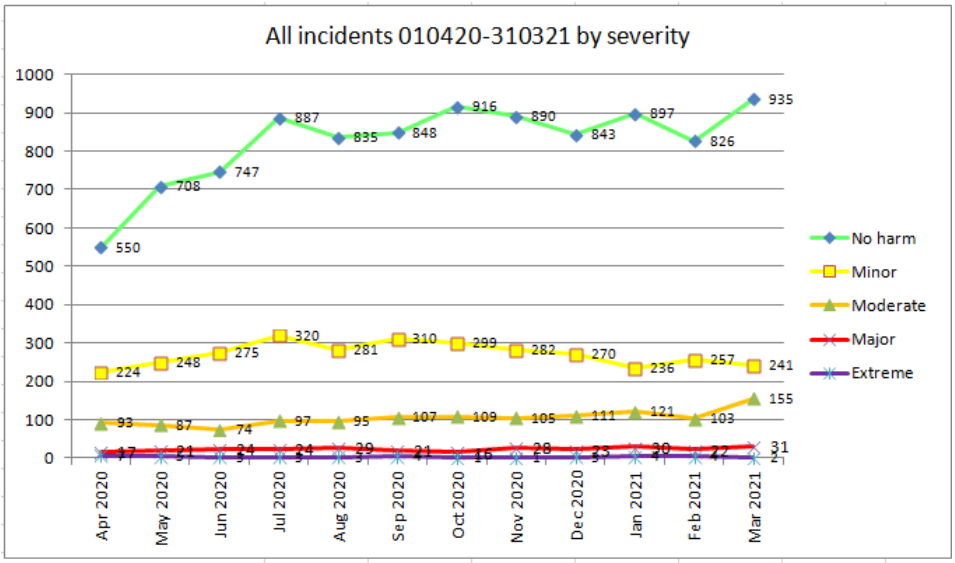
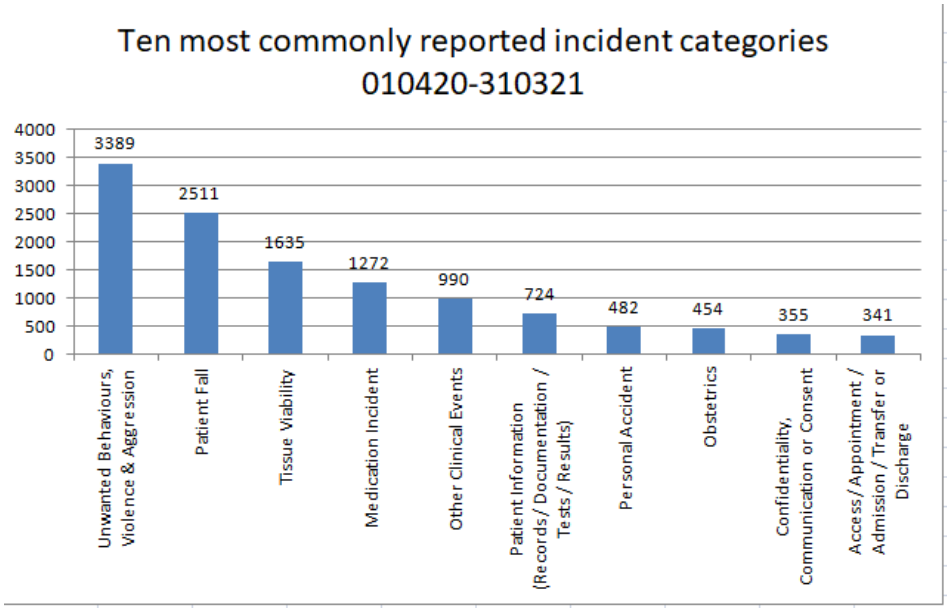


Chart 2



Other Clinical Events' contains discrete sub categories including 'Delay in Treatment', 'Failure of Diagnosis & Referral', 'Misdiagnosis'.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 June 2021**
Title:	**Feedback from the Sharing Intelligence for Health & Care Group**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- National Health & Well-Being Outcomes

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Audit & Risk Committee with the annual feedback received from the Sharing Intelligence for Health & Care Group's recent review of NHS Fife. The Group is a mechanism that enables seven national organisations to share, consider and respond to intelligence about care systems across Scotland, in particular NHS Boards. The seven organisations, each of which has a Scotland-wide remit, are: Audit Scotland, Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, Public Health & Intelligence (part of NHS National Services Scotland), and Scottish Public Services Ombudsman. The Group considers information already held by the various organisations, including a range of information that is already in the public domain.

2.2 Background

The establishment of the Sharing Intelligence for Health & Care Group (SIHCG) was an important part of Scotland's response to a recommendation to improve intelligence sharing

within and amongst national agencies. This recommendation was made in 2013 following a public inquiry into the serious failings at Mid Staffordshire Foundation NHS Trust. The Group was established in 2014 with the aim of supporting improvement in the quality of care provided for the people of Scotland by making good use of existing data and intelligence. Its main objective is to ensure that, when any of the seven agencies on the Group have a potentially serious concern about a care system, then this is shared and acted upon appropriately. Sharing concerns at the right time can help identify emerging problems which can then be acted upon.

It is important to note that this does not allow the Group to make a comprehensive assessment of the quality of care in an individual Board, nor is it the role of the Group to do so. The agencies on the Group report that there is now much better sharing and consideration of key pieces of intelligence, and they are now much better prepared to take additional action when this is required.

The Group provide feedback to each of the NHS Boards they consider, initially in the form of a feedback letter. A follow-up meeting with the respective NHS Board is then scheduled, at which is considered key issues raised within the written report. NHS Fife received their written feedback letter on 28 May and a follow-up meeting to discuss this, between Directors and representatives from the Group, will be scheduled in due course over the summer period.

2.3 Assessment

The feedback letter on NHS Fife is enclosed for the Committee's information. There were three main issues highlighted: ongoing concerns about mental health and learning disability services in Fife, including the estate for these services and the number of delayed discharges within learning disability; issues with accountability in the Fife H&SC Partnership for community engagement and participation work; and the need to finalise the ongoing review of the Fife Integration Scheme, to enhance the clarity of responsibilities and relationship between NHS Fife and Fife Council, particularly around the risk share. Some minor comments were made around improving the complaints handling processes; addressing the number of consultant vacancies and costs for temporary medical staff; and the need to take forward medium-term financial planning to address challenges around financial sustainability. Follow-up discussion will be held on these points when representatives from the Group meet with Directors.

Positive progress was also highlighted, namely: improved stability in the senior leadership of NHS Fife and the Fife H&SC Partnership; improved openness and transparency by virtue of the new NHS Fife website providing easier access to information; positive findings of two recent HIS inspections of Glenrothes and Adamson hospitals, particularly around infection control; and the Board's achievement of the Scottish Stroke Care Audit standard on 'time to thrombolysis'. The Board's response and leadership in the context of the Covid-19 pandemic was also recognised.

2.3.1 Quality / Patient Care

Consideration of the SIHCG feedback is an important indicator of our quality and safety standards, it being indicative of the findings of, and information held by, various external regulators.

2.3.2 Workforce

There are no workforce implications from this paper.

2.3.3 Financial

There are no financial implications from this paper.

2.3.4 Risk Assessment/Management

N/A.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

As described within the feedback letter, the written report summarises the findings of the Group's review of information held by seven external agencies. This letter is expected to be published by the SIHCG once the follow up discussion meeting with NHS Fife has taken place.

2.3.8 Route to the Meeting

This feedback from the SIHCG letter has been considered initially by relevant Directors and will be reviewed in detail with the SIHCG at the forthcoming feedback meeting (date of which is TBC).

2.4 Recommendation

The paper is provided to the Audit & Risk Committee for:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix – SIHCG Feedback Letter, 19 May 2021

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19 May 2021

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Ms Carol Potter
Chief Executive
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KY2 5AH

Dear Ms Potter

Feedback from the Sharing Intelligence for Health & Care Group – NHS Fife

The Sharing Intelligence for Health & Care Group (referred to as 'the Group') considered NHS Fife at our meeting on 26 April 2021, as part of our routine annual programme of work. We are writing now to summarise the main points we discussed collectively as seven national organisations.[1]

First, we would like to thank colleagues from NHS Fife and Fife Health & Social Care Partnership for their tremendous efforts in the ongoing response to the COVID-19 pandemic. We know that the pandemic will continue to cause enormous challenges for front line services for some time to come, and there will be an impact on those heavily involved in the COVID-19 response even once the current challenges recede.

[1] The Sharing Intelligence for Health & Care Group is a partnership involving: Audit Scotland; Care Inspectorate; Healthcare Improvement Scotland; Mental Welfare Commission for Scotland; NHS Education for Scotland; Public Health Scotland, and: Scottish Public Services Ombudsman.

The pandemic has also impacted on the work programmes of the seven national organisations on the Group, and in doing so on some of the intelligence that is available to us. We are, however, continuing to share and consider intelligence regularly – as this helps us identify things that are working well, and also any emerging problems which can then be acted upon. The remit of the Group does not, however, extend to making a comprehensive, system-wide assessment of the quality of care. The intelligence we considered on 26 April should already be known to NHS Fife, including a range of information which is already in the public domain.

NHS Fife

When we considered NHS Fife on 26 April 2021, partner agencies on the Group found it helpful to learn from each other about various aspects of the health and social care system in the Fife. This will help inform the work we carry out as national organisations. As explained below, the Group has significant and ongoing concerns about mental health and learning disability services in Fife. We wish to meet again with you and your team (including input from Fife Health & Social Care Partnership) to learn about the progress made in responding to these issues. The Group will also consider this issue again in October 2021 to decide whether or not there are any additional actions beyond any already planned that any of these agencies need to take.

As a Group, we have previously acknowledged the environment of extreme pressure that the leaders of today's health and social care systems are working within. There has also been a significant level of change across Scotland within the senior leadership of NHS boards – and we acknowledged the ongoing changes to the senior leadership of NHS Fife. We noted that you have now taken up the role of Chief Executive on a permanent basis, and your Director of Finance & Strategy has also recently been confirmed as a permanent appointment. There have been recent appointments to the roles of Director of Nursing, and Director of Property & Asset Management – and you are also seeking to recruit to your Director of Public Health post.

We have previously highlighted some concerns with the operation of Fife Health & Social Care Partnership – noting that the Accounts Commission had emphasised the need for the partnership to strengthen its financial management and performance reporting, and for there to be greater clarity of its responsibilities and relationships with NHS Fife and Fife Council. We understand that progress has been made in relation to some of these issues and also that, after a prolonged period of change in senior leadership, the Chief Officer and Chief Finance Officer of Fife Health & Social Care Partnership have now been in post for about two years. At our meeting on 26 April 2021, Audit Scotland explained that a review of the Integration Scheme is in progress – however there are challenges in agreeing revisions to the risk share agreement which applies in the event of an overspend on integrated services. Healthcare Improvement Scotland informed the Group that there are also issues with accountability in the partnership for community engagement and participation work. In contrast, Healthcare Improvement Scotland has a good working relationship with NHS Fife's Person Centred Care Team. Fife's Participation and Engagement Advisory Group's work is progressing well, and would benefit from more buy in and collaboration with the partnership.

In terms of openness and transparency, NHS Fife has launched a new website, improving accessibility of Board and Committee papers. The Care Inspectorate explained that there is good engagement between the Partnership and link inspectors, and there appears to be openness and transparency.

Audit Scotland informed the Group that NHS Fife's continued reliance on non-recurring financial savings means that it will have ongoing challenges in achieving financial sustainability. A medium-term financial plan is in development. NHS Fife's transformation programme was expected to progress in 2020, but was stalled as a result of the pandemic.

NHS Education for Scotland explained that the percentage of consultant vacancies for NHS Fife is higher than the Scottish average. Vacancies for nursing and midwifery, and also for Allied Health Professionals, are more comparable with the national level. We understand that costs for temporary medical and nursing staff have increased.

The Mental Welfare Commission for Scotland has previously drawn the Group's attention to the ongoing need to redesign and refurbish the buildings/environments for adult acute mental health wards in Fife, to ensure that these are conducive to recovery. The Commission has also raised this with Scottish Government, given the ongoing nature of these concerns and the investment required to make the necessary changes. At our meeting on 26 April 2021, the Commission explained they continue to be kept updated of capital planning work, which is still at an early stage – and the Executive Medical Director has agreed to keep the Commission up-to-date with progress. When local visits are re-established, the Commission has prioritised the acute inpatient areas to review what work is planned/has been commenced. The Commission has also raised concerns with Fife Health & Social Care Partnership about delayed discharges in learning disability services, and has been advised of the planned work to address this.

Healthcare Improvement Scotland carried out inspections during 2020 at Glenrothes Community Hospital and Adamson Community Hospital. Neither inspection identified patient safety concerns. Compliance with standard infection prevention and control precautions was good, and wards appeared calm and organised with evidence of team working. Staff (both nursing and domestic) had been provided with appropriate training and felt supported by the infection prevention and control team. NHS Fife engaged well during both inspections, and provided detailed action plans to address inspection findings.

The Care Inspectorate explained that Fife Health & Social Care Partnership is performing well overall in relation to key indicators for integration. Drug and alcohol related deaths in Fife are, however, increasing, and we understand that steps are being taken to learn about the circumstances underlying these deaths and how these might then be addressed.

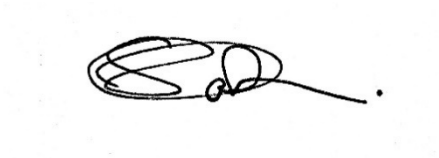
The Scottish Public Services Ombudsman highlighted that, for around half of the cases for NHS Fife closed at investigation stage, there were recommendations for improvement in an aspect of complaints handling, eg not directing patients to the complaints procedure appropriately, failing to identify and investigate all of the substantive points of complaint, not keeping patients up-to-date with delays. We understand that NHS Fife is making changes with the aim of improving complaints handling. We noted that, based on Care Opinion stories, NHS Fife is currently relatively high compared to the Scottish average for the percentage of areas of care being reported as good by people experiencing care.

Public Health Scotland noted that NHS Fife's achievement of the Scottish Stroke Care Audit standard on 'time to thrombolyisis' had shown a sharp improvement over the past 6 months.

We note from your board papers that there are vulnerabilities in the Community Paediatric Service, and further service redesign is ongoing to develop a sustainable clinical service.

We hope you find this summary of our discussions helpful, and we would be grateful if you share this letter with Fife Health & Social Care Partnership, together with the Board of NHS Fife. We will also welcome your feedback on how we can improve how we share and use intelligence as a Group, including how this can be of greatest value to NHS Fife.

Yours sincerely



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